EPART MENT OF HEALTH AND HUMAN SERVICES									
ENTERS FOR MEDICARE & MEDICAID SERVICES									
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) I						
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	00	l c						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393		A. BUILDIN B. WING				(X3) DATE SURVEY COMPLETED 09/08/2011	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PRE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
W0000	revisit (PCR) to recertification a completed on 7/resulted in an Irr Dates of Survey and 8, 2011. Surveyor: Dott Surveyor III Facility Number AIM Number: Provider Number in accordance with the following of in accordance with receiving and surveyor in accordance with receiving the following of in accordance with receiving the receiving accordance with receiving the receiving t	100244410	W000	00				
W0102	The facility must governing body a requirements are Based on observinterview for 4 (#2, #3, and #4), (#5, #6, #7, and	•	W010)2	Senior managementi has reviewe agency policies and procedures regarding prohibiting clienti abust and neglecti. Iti was detiermined agency policies are clearly define regards tio prohibiting abuse and	e tihati	09/22/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HVBK12

Facility ID:

000907

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		15G393	B. WIN			09/08/20)11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		1	I VERNON, IN47265		
					1 12 11 10 11, 11 17 200		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		. +	DATE
	Governing Body	.			neglecti. Stiaft have been retiraine	ea	
					on tihese policies. A Behavioral Clinician has been obtiained ftor		
	Findings include	:			Clienti#8 and a Behavior Supporti		
					Plan has been developed tio coinc	ide	
	Please refer to W	/104 for 4 of 4 sampled			witih tihe Plan oft Action tihati wa	- 1	
	clients (#1, #2, #	3, and #4), and 4			modifted. Clienti#8's guardian has		
	l ` ´ ´	s (#5, #6, #7, and #8), for			given verbal approval ftor botih		
		ody's failure to exercise			plans. HRC approval was obtiaine	d	
	ı	g direction over the			ftor botih plans and all stiaft have		
	1 '	-			tirained A new psychiatiristi has b	een	
	,	g to implement policies			contiactied ftor Clier#8 as well as a	a	
	_	which prohibited client			counselor. Appointimentis are be	ing	
	neglect and abus	e.			scheduled ftor each oft tihese		
					Modiftcations are being made in t		
	Please refer to W	/122 Condition of			home tio provide a privatie room	- 1	
	Participation: Cl	ient Protections for 4 of 4			Clienti#8. This will in tiurn provide	- 1	
	sampled clients	(#1, #2, #3, and #4), and 4			privatie room ftor Clien#4 who wa Clienti#8's roommatie All clienti's		
	additional clients	s (#5, #6, #7, and #8), for			bedroom doors now have door		
		lecting to implement			handles tihati lock Each clienti has		
	, ,	cedures which prohibited			been provided a key tio her door, i		
	1	all and physical abuse of			addition stiaft have a key tio each		
		lity also failed to report,			door. Additional stiaft have been		
		•			added tio each shift tio ensure tihe	e	
		mplement remedies			healtih and saftetiy oft all resident	is in	
	1 ~ ~	, emotional and physical			tihis home. QIDP Assistianti or SGI	-	
		This failure resulted in			Division manager (acting QIDP), w	- 1	
	Immediate Jeopa	ardy.			do observations in tihe home ati le	- 1	
					weekly ftor one montih tio ensure		
	Please refer to W	7266 Condition of			plans are being implementied and policies and procedures are uphel		
	Participation: Client Behavior & Facility				Random observations will continu		
	Practices for 4 of 4 sampled clients (#1,				after one montih	~	
	#2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), for the facility's failure to implement, revise and manage				Responsible for QA: Senior		
					Management, SGL Division		
					Manager, QIDP		
	1	l, emotional and physical					
		#1 #2 #3 #4 #5 #6 and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393		15G303	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/08/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	#7. 1.1-3-1(a)							
W0104	policy, budget, and the facility. Based on observe interview for 4 of #2, #3, and #4), a (#5, #6, #7, and #4) failed to exercise direction over the implement policies	dy must exercise general doperating direction over ation, record review and f 4 sampled clients (#1, and 4 additional clients (#8), the Governing Body e general operating e facility by failing to es and procedures which neglect and abuse.	W0104	Senior managementi has reviewed agency policies and procedures regarding prohibiting clienti abuse and neglecti. Iti was detiermined tagency policies are clearly deftned regards tio prohibiting abuse and neglecti. Stiaft have been retiraine on tihese policies. A Behavioral Clinician has been obtiained ftor Clienti#8 and a Behavior Supporti	cihati d in			

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Event ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL: A. BUILDI		STRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G393	B. WING			09/08/2011
	PROVIDER OR SUPPLIER			113 JENI	DDRESS, CITY, STATE, ZIP CODE NINGS ST VERNON, IN47265	
DEVELO (X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIENCE REGULATORY OR Findings include: The Governing B general policy an over the facility is body neglected to policies and proceed the verbal, emotion of clients #1, #2, client #8 which responsible to the policies and proceed (and) Protection. Purpose: "To establish policies and Proceed (and) Protection. Purpose: "To establish policies the forefront of seal and the policies and proceed (and) Protection. Purpose: "To establish policies and proceed (and) Protection.	RATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Body failed to exercise d operating direction In that the governing o implement written edures which prohibited onal and physical abuse #3, #4, #5, #6 and #7 by esulted in Immediate y policies and procedures O PM and on 9/08/11 at d the 4/12/2006 Standard dure for Individual Rights icies and procedures to g, safety and rights of d by (the agency) are at ervice delivery. Fing the potential or Interported, investigated and taken to alleviate the re riskIt is the Interported in the exercise Interport of the potential or Interport of the potenti	PR			DATE dide s dide been een ng he ttor a a s s
	protection."					

000907

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G393	A. BUIL	DING	00	COMPL 09/08/2	
		100090	B. WINC		A DEDUCA CAMPA CAMPA CAMPA CAMPA	09/00/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NNINGS ST		
DEVELO	PMENTAL SERVICI	ES INC			VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		127 for the facility	+	IAG	Dia relation,		DATE
		•					
	failure to prevent physical, emotional and verbal abuse of clients.						
	verbar abuse of c	Hents.					
	1.1-3-1(a)						
11/01/22	The facility must a	nours that apositis aliant					
W0122	protections require	nsure that specific client ements are met.					
	Based on observa	ation, record review and	W(0122	A Behavioral Clinician has been		09/22/2011
	interview for 4 of	f 4 sampled clients (#1,			obtiained ftor Clien#8 and a		
	#2, #3, and #4), a	and 4 additional clients			Behavior Supporti Plan has been		
		#8), the facility failed to			developed tio coincide witih tihe P oft Action tihati was modiftedClien		
	meet the Condition	on of Participation:			#8's guardian has given verbal	u	
	Client Protection	S.			approval ftor botih plans HRC		
					approval was obtiained ftor botih		
	Findings include:				plans and all stiaft have been		
					tirained A new psychiatiristi has b		
	Based on observa	ation, record review and			contiactied ftor Clier#8 as well as a counselor. Appointimentis are bei		
	interview for 4 of	f 4 sampled clients (#1,			scheduled ftor each oft tihese	6	
	#2, #3, and #4), a	and 4 additional clients			Modiftcations are being made in t	he	
		#8), the facility failed to			home tio provide a privatie room f		
		of all clients to be free of			Clienti#8. This will in tiurn provide		
	•	motional and physical			privatie room ftor Clien#4 who wa Clienti#8's roommatie All clienti's	s	
		to address client #8's			bedroom doors now have door		
		y destruction, physical			handles tihati lock Each clienti has		
	and verbal aggres	ssion.			been provided a key tio her door, i	n	
					addition stiaft have a key tio each		
		opardy was identified on			door. Responsible ftor QA QIDP/SGL		
		PM that had existed at			Manager Manager		
		9/01/2011 at 4:10 PM.					
		ervised Group Living					
	Division Manage	er, was notified of the					
					<u> </u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
111,12 12,111	or confidence.	15G393	A. BUII B. WIN			09/08/2	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R			ININGS ST		
DEVELO	PMENTAL SERVIC	CES INC		NORTH	VERNON, IN47265		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG			-	IAG	,		DAIL
	Immediate Jeopardy on 9/01/2011 at 5:50 PM. The facility offered a Plan of Action						
	1	nmediate Jeopardy on					
	1	5 PM which included the					
	following:						
	"Immediate action	on taken:no less than 2					
		sic.) be on duty any time					
	1	esent in the home until					
	further notice.						
	Extra staff was a	arranged for overnight					
	tonight 9/1/11. (Client #8) will be going					
	home 9/2/11 after	er work and will not					
	return until Mon	day afternoon 9/5/11. A					
	second staff pers	son has been scheduled					
		ift starting again on 9/5/11					
	and will continu	e until further notice."					
	"Plan of Action	to remove Immediate					
	Jeopardy:						
	1. At least 2 staf	f will be on duty any time					
	(client #8) is pre	esent in the home					
	regardless of the	number of other clients					
	present.						
	1	n glass such as mirrors					
	_	es will be removed from					
		as in the house until					
	further notice.						
	1	upon (client #8) exhibiting					
	1	g anger and aggression					
		cursing, stating she is					
	_	ng physical threats against					
	1	ne staff person will direct					
	and ensure all of	ther clients are moved to a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	C	(X3) DATE SURVEY COMPLETED		
		15G393	A. BUII B. WIN	LDING			09/08/20	011
			B. WIN		DDRESS, CITY, STAT	TE. ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R			NINGS ST	,		
DEVELO	PMENTAL SERVIC	ES INC		1	VERNON, IN47	265		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCEI	E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	:	COMPLETION DATE
IAG		<u> </u>		TAG	BELL	chave 1)	+	DATE
		rom (client #8) and						
	remain with them until all clam (sic.). 4. Immediately upon (client #8) exhibiting							
		g anger and aggression,						
	•	she is upset, and making						
		self or others, second						
	•	place themselves						
	,	#8) and other clients in						
	<i>'</i>	n maintaining a safe						
	`	lient #8), began talking						
	(sic.) calmly to h	•						
	strategies outlined in her Behavior							
	Support Plan.							
	` '	behavior becomes						
	^	physically threatening to						
		nues for more than 15						
		ualified Intellectual						
		essional/on call pager will						
		11 will be called. This						
	* *	uous aggressive behavior						
	toward others. It	does not apply to						
	situations in whi	ch (client #8) is						
	aggressive once	but calms herself.						
	6. If (client #8's)	destructive behavior is						
	only directed tov	vard her own property,						
	staff should mak	e no attempt to prevent						
	this. Staff should	ONLY intervene if her						
	actions are causi	ng harm to herself. If this						
		vior continues without						
	physical threats t	to herself or others for 45						
		ll notify QIDP/on call						
	pager and 911 will be called.							
	Further action Pl	anned:						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	HVBK12	Facility II	D: 000907	If continuation she	et Pac	ie 7 of 75

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		A. BUII	LDING	NSTRUCTION 00	` ′	E SURVEY PLETED //2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODI ININGS ST VERNON, IN47265		2011
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION
TAG	(Client #8's) psycontacted in regaseverity of her become was requested bus order a new med current medicating given approval for Rights Committed sought. IDT (interdisciples soon as possible behaviors and replan to address in aggressive behave (Group Living Deformation (QIDP) will be replan is implement removing the risk plan is implement removing the risk plan. The interview with step indicated QID Disabilities Profession and had since to offer training and the facility on 9/0 been training state of the every state of	rds to the increase and chavior. An appointment at the doctor chose to ication to be added to her cons. Her guardian has for this and HRC (Human ree) approval is being tinary team) will meet as to review current wise Behavior Support increase (client #8's)		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE COI LDING	NSTRUCTION 00	COMPL	ETED	
		15G393	B. WIN			09/08/2	011
	ROVIDER OR SUPPLIER		-	113 JEN	DDRESS, CITY, STATE, ZIP CODE ININGS ST		
DEVELOR	PMENTAL SERVICI			NORTH	VERNON, IN47265		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		n the left upper arm area					
		the kitchen area after					
	-	green beans on the table.					
		'leave me alone, stop					
		' and frowned at client #8					
	as she touched he						
		n and drew back her right					
	•	st toward client #2.					
	Clients #1, #2, #3	3, #4, #5, #6, #7, and #8					
		have dinner at the					
	-	M. Staff #5 was observed					
	to sit with clients	#4 and #5. Staff did not					
	sit at the table wi	th clients #1, #2, #3, #6,					
	#7 and #8. Durin	g bathing time on					
	9/06/11 at 6:30 P	M, client #8 exhibited					
	frustration while	waiting for client #4 to					
	be done with the	bathroom. Staff #9					
	checked on client	t #4 and indicated to					
	client #8 she wou	ald be done soon and to					
	be patient. Staff	#5 and #9 were observed					
	to be in the facili	ty's office area and staff					
	#6 was in the acc	essible bathroom bathing					
	client #3 at 6:40	PM. At 6:40 PM, client					
	#8 was observed	to open the bathroom					
	door and express	ed her frustration toward					
	client #4, who wa	as still in the bathroom.					
	Phone interview	with staff #6 on 9/07/11					
	at 7:55 PM indica	ated client #8 had					
	another behaviora	al outburst on 9/06/11					
	after the surveyor	r left the facility. The					
	-	ed the police had been					
	called owing to the	he unmanageable					
	behaviors exhibit	ted by client #8. Phone					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		15G393	A. BUIL B. WING			09/08/2	
NAME OF I	PROVIDER OR SUPPLIEI	 	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	PMENTAL SERVIC			l	NNINGS ST I VERNON, IN47265		
				<u> </u>	I VERNON, IN47205		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	interview with s	taff #5 on 9/07/11 at 8:06					
	PM indicated client #8 had become upset						
		/06/11 and had thrown a					
	_	etronic keyboard in the					
	1 *	m hallway. The client had					
	1 ^	ype chair up the hallway					
	1	g area. Staff #6 had taken					
	1 ' '	4, #5, and #6 into clients					
		oom for safety. Clients #3					
		ready in bed for the night the other clients were					
		afety." The interview					
		#8 tried to get into the					
	clients' bedroom	•					
	Interview with C	Group Living Division					
	Manager/Admin	istrator #1 on 9/08/11 at					
	11:00 AM indica	ated client #8 had severe					
	behaviors on the	evening of 9/06/11 and					
		ed to intervene, the staff					
		the eye. 911 was called					
	1	facility's Plan of Action					
	of 9/01/11 and c	lient #8 calmed herself.					
	Group Living D	 Nicion					
	1 .	istrator #1 was notified					
	_	15 PM the Immediate					
		of removed due to the					
		of the 9/01/11 Plan of					
		ailure to keep clients safe					
		erbal and emotional					
	abuse.						
	Please refer to V	V127 for 4 of 4 sampled					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or connection	15G393	A. BUI		00	09/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		1	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	clients (#1, #2, #		+	IAU			DATE
	· · · · ·	s (#5, #6, #7 and #8), for					
		are to ensure the rights of					
	1	free from physical, verbal					
		al abuse by a peer.					
	and psychologica	ir douse by a peer.					
		7148 for 1 of 4 sampled					
	\ //	2 additional clients (#6					
	· · · · · · · · · · · · · · · · · · ·	acility's failure to have					
		nts' guardians were					
	notified of significant incidents occurring						
	in the facility.						
	Please refer to W	149 for 4 of 4 sampled					
	clients (#1, #2, #	•					
	· ·	s (#5, #6, #7 and #8), for					
	the facility's failu	ire to implement written					
	policies and proc	edures which prohibited					
	mistreatment, ne	glect or abuse of clients.					
	Please refer to W	153 for 8 of 8 reportable					
		ed (clients #1, #2, #3, #4,					
		ne facility's failure to					
	· · · · · · · · · · · · · · · · · · ·	ort allegations of client to					
	1 1	erbal and psychological					
		ficials (Bureau of					
	Developmental I	Disabilities					
	1 -	in accordance with State					
	law through estal	blished procedures.					
	Please refer to W	154 for 3 of 8 reportable					
		ed, (clients #3 and #4),					
		failure to ensure all					
	· ·	thoroughly investigated.					
	L arregations were	morouginy investigated.					

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/08/2011
	PROVIDER OR SUPPLIER		113 JEN	ADDRESS, CITY, STATE, ZIP CODE NNINGS ST I VERNON, IN47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0127	clients. Therefore that clients are not verbal, sexual or punishment. Based on observation interview for 4 or #2, #3 and #4), proceeding the first from physical, verballing to the facility on the even 4:40 PM until 7:0 the facility 4:40 I broken pictures with the facility 4:40 I br	nsure the rights of all, the facility must ensure is subjected to physical, esychological abuse or action, record review, and if 4 sampled clients (#1, lus 4 additional clients 8), the facility failed to of the clients to be free erbal and psychological created at the ening of 9/01/11 from 20 PM. Upon entrance to PM, broken glass and were observed to be on cont living room hallway	W0127	A Behavioral Clinician has been obtiained ftor Clien#8 and a Behavior Supporti Plan has been developed tio coincide with the oft Action tihati was modiftedClie #8's guardian has given verbal approval ftor botih plans HRC approval was obtiained ftor botih plans and all stiaft have been tirained A new psychiatiristi has contiactied ftor Clien#8 as well as counselor. Appointimentis are be scheduled ftor each oft tihese Modiftcations are being made in home tio provide a privatie room Client#8. This will in tiurn provid privatie room ftor Clien#4 who w Clienti#8's roommatie All clientf's bedroom doors now have door	peen a eing tihe ftor e a

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
11.12.12.11.	or conduction	15G393	I ' -	LDING		09/08/2011
		10000	B. WIN		DDDEGG CITY CTATE ZID CODE	1 00.00.2011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE	
DEVELO	PMENTAL SERVIC	ES INC			VERNON, IN47265	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG	 	family room. The family		IAG	handles tihati lock Each clienti ha	
		ras in disarray. A clear			been provided a key tio her door,	1
		ved to be on the kitchen			addition stiaft have a key tio each	
	1 ^	ing room tables were out			door.	
		was observed to be			Responsible ftor QA QIDP/SGL	
	_	h in the family room with			Manager	
		#8 was lying on the				
		lients #1, #2, #3, #4, #5,				
		observed to be grouped				
	1	cility's office/medication				
	_	#6. Clients #1, #2, #3, #4,				
		mained in the facility's				
	l ' '	#4 obtained the vacuum				
	cleaner and starte	ed to vacuum up the				
		side the door to the office.				
	Client #8 vacuun	ned some of the glass				
	with assistance b	y staff #5 who also used				
	a broom and dus	tpan. Staff #5 and client				
	#8 dried the kitcl	nen floor and rearranged				
	the furniture.					
	At 5:12 PM, clie	nts #1, #2, #3, #4, #5, #6,				
	and #7 were obse	erved to leave the office				
		was observed to finish				
	cooking the even					
		eese, green beans, and				
	fruit at 5:30 PM.					
		3, #4, #5, #6, #7, and #8				
		sit down to together and				
	_	neal at 5:45 PM. Staff #5				
		sit with clients #1 and #5				
		ar area. Clients #2, #3,				
		8 were observed to sit at				
	_	without staff sitting with				
	them. Staff #6 w	vas observed to be				

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Event ID:

HVBK12 Facility ID:

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	li i	e survey pleted /2011
	PROVIDER OR SUPPLIER		STREET 113 JE	ADDRESS, CITY, STATE, ZIP C NNINGS ST H VERNON, IN47265	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	standing in the dinot beside client observed to sit won the right and corner of the table #2 left the facility. Review of facility (Adverse Incident Adverse Incident Inci	ining room area but was #8. Client #8 was ith client #6 beside her client #3 around the te to client #8's left. RN by at 6:00 PM on 9/01/11. The provident reports at Reports/AIR and the Reports/AIR and the Reports/MIR on 9/02/11 at 10:15 AM indicated with the provident ent #4 items off walls, broke the over two chairs and the ocked glasses off of the occupation of the provident walls with the provident ent #4 items off walls would cut to all aggressive (called "b" told peers she yelled "I will kill the me a knife I'll cut all aff #9 on 8/27/11 from 40 PM indicated client #8 items off walls would cut to all aggressive (she punched and spit on staff, attacked ag them in the head);				

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED	
		15G393	B. WIN			09/08/2011	
			P. (711)		ADDRESS, CITY, STATE, ZIP CODE		\dashv
NAME OF F	PROVIDER OR SUPPLIER				NNINGS ST		
	PMENTAL SERVIC	ES INC		1	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	\dashv
		y (pulled items off walls					
		s and mirrors, threw					
		the room); non-compliant					
	(argued with staf	f); and verbally					
	aggressive (cursi	ng and yelling at staff					
	and peers).						
	3. A MIR dated	8/27/11 at 8:15 PM by					
	staff #10 indicate	-					
	physically aggres						
	1	at #4 who was asleep,					
		ching her leaving a 3					
		mark to her right cheek					
	·	_					
		wo inches long on the					
	right side of her	песк.					
	4. A MIR dated	8/27/11 at 8:15 PM by					
	staff #10 indicate	ed client #8 was					
	physically aggres	ssive toward client #5					
	while she was in	bed. Client #8 went into					
	her room and sla	pped her. Client #5 had					
		left upper arm and left					
		tch on her left thumb.					
	5. A MIR dated	8/27/11 at 8:15 PM by					
		ed client #8 had smacked					
		a reddened area on the					
	left side of her fa						
	6. A MIR dated	8/27/11 at 8:15 PM by					
	staff #10 indicate	ed client #8 was					
	physically aggres	ssive toward client #1 in					
		ped her and knocked her					
		her face. Client #1 had					

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE 00 COMPLETED				
ANDILAN	or conduction	15G393	A. BUI		00	09/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00:00:2	
NAME OF I	PROVIDER OR SUPPLIER				NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		1	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU		· · · · · · · · · · · · · · · · · · ·	-	IAG	DEFICIENCE (DATE
	red areas on her	right cheek.					
	7 A MID dated	8/25/11 by staff #5 at					
		ed client #8 had slapped					
		ht side of the face.					
	noisen on the fig	in side of the face.					
	8. A MIR dated	8/25/11 by staff #5 at					
		ed client #4 reported					
		her on the left upper leg,					
	right upper arm a	11 0					
	9. A MIR dated	8/25/11 by staff #5 at					
	3:10 PM indicate	ed client #7 had become					
	agitated on the va	an when client #8 had					
	started yelling.						
	10. A MIR dated	8/25/11 by staff #5 at					
		ed client #3 reported					
		atched her on the right					
		marks. The first was 3					
		he second was 2 inches					
	in length.						
	Review of client	#3's record on 9/02/11 at					
		ated an entry by staff #9					
		7:00 AM to 10:00 PM					
		"became very upset					
		had behavior (sic.) crying					
	·	o home. Stating (sic.) she					
		here anymore." An entry					
		PM to 8:00 AM shift					
		I client #3 was crying at					
		sn't want to be here					
		to go home due to (client	\perp				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	
		15G393	B. WING			09/08/2	011
NAME OF F	PROVIDER OR SUPPLIEF	\ \			DDRESS, CITY, STATE, ZIP CODE		
ם אורן ס	DMENTAL OFFICE	EO INO	I		ININGS ST		
	PMENTAL SERVIC	ES INC			VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES	- 1	D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· `	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		atburst." The entry by	1	AG			DATE
	l '	d client #3 was still upset					
	the morning of 8	•					
		/20/11.					
	Review of client	#8's record on 9/02/11 at					
		ed a Case Analysis					
		d 2/28/11 which included					
		rding her history. The					
		ated client #8 "expresses					
		rough behavioral					
		than being able to talk					
		tions and implementing					
		n herself." The Case					
	_	ed no formal diagnoses					
	1 -	indicated she "has a long					
		onal and behavioral					
	· -	according to the Case					
		ent has exhibited "major					
	1	d swings, explosive					
	_	If injurious behaviors."					
		sis indicated client #8 had					
	1	ore for behavioral issues					
		or 5 years old" and she					
	has had "several						
		the most recent occurred					
	in "approximatel						
		w indicated client #8 had					
		the facility on 5/28/11.					
		ort program/ISP dated					
		#8 indicated she was					
		otropic medications for					
	1 1 1 1	pram (antidepressant) 40					
	· ·	daily, risperadone					
	(antipsychotic) 2						
	mg./milligrams o	laily, risperadone					

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		INSTRUCTION 00	(X3) DATE :	ETED
		15G393	B. WIN			09/08/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		NORTH	I VERNON, IN47265		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ng. twice daily for the					
		e medications. The ISP					
		48 had the behaviors of					
	1	d aggressive behaviors not been revised when					
		ed the violent behaviors					
	on 8/27/11.	ed the violent behaviors					
	The 0/02/11 0:20	3 AM record review					
		in client #8's record on a					
	daily basis by dir						
	1 ' '	1/11 by staff #3 indicated					
	I -	en "telling everyone to go					
	home and saying						
		entry indicated client #8					
	I -	arm, called her dad, then					
		hrew her cell phone.					
		nto a peer's room and					
	knocked over her	-					
	On 8/21/11, staff	F#9 indicated client #8					
	had had "several						
		ay with several peers.					
	Cursing and boss	sing."					
	On 8/25/11, staff	F#3 indicated client #8					
	was "upset as soo	on as she got in (sic.) van					
	at w/s (workshop	o) today."					
	On 8/27/11, staff	F#9 indicated client #8					
	· ·	ouch watching tv					
	1	egan yelling and cussing.					
	l ` ′	are and pictures (sic.)					
	breaking a mirror	r. 4 peers wore (sic.)					

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Event ID:

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 00 COMPLETED				
ANDILAN	or connection	15G393	A. BUII		00	09/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER			1	NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		1	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	1 1 staff was punched in					
	the face and anot	her spit on x2 (twice)."					
	Interview with R	N #2 on 9/01/11 at 4:35					
	PM indicated clie	ent #8 had a tantrum and					
	broke mirrors and	d threw furniture. The					
	RN indicated clie	ent #8 broke pictures					
		picked up some of the					
		ned to cut herself. RN #2					
	~	48 had wanted to eat but					
	dinner was not re	eady. The interview stated					
	client #8 had beh	•					
	warning." The in	terview indicated client					
	·	#2 in the left eye. The					
		ed client #8 had hit her					
	peers (clients #4	and #5) last weekend.					
	^ `	N #2 on 9/01/11 at 4:55					
	PM indicated the						
		psychotropic medication					
	change but it had						
	_	cause the necessary					
	·	t yet been obtained.					
	Client #2 stated of	on 9/01/11 at 4:50 PM					
	that "(client #8) h	nit me in the left eye."					
	 Client #5 stated a	on 9/01/11 at 4:48 PM					
		t to get beat up again."					
		on 9/01/11 at 6:20 PM: "I					
		appen again, that's all. I					
		appen again. But, I'm					
		to." Client #5 stated					
		t my arm, I was laying in					
		d my left hand. She was					
	ocu, siic scratche	a my left hand. She was					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G393	B. WIN	G		09/08/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		NORTE	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG	 	could not see her dad"		TAG	DEFICIENCE!)		DATE
	last Saturday (8/2	2//11).					
		#2, #3, #4, #5, #6 and #7),					
		ere afraid of client #8					
	1	d on 9/01/11 at 4:53 PM.					
	when interviewed	u on 7/01/11 at 4.33 1 W.					
	Client #3 indicate	ed, on 9/01/11 at 6:25					
	PM, client #8 had	d behaviors last Saturday					
	(8/27/11) at bedti	ime wherein client #8 hit					
	client #4 and (cli	ent #8's room-mate was					
	client #4) broke i	mirrors and pictures and					
	awoke and fright	ened client #3's					
	room-mate, clien	t #7.					
	On 9/02/11 at 6:1	15 AM, staff #9 was					
	interviewed. Staf	ff #9 indicated clients #4					
	and #8 shared a b	pedroom the previous					
	night and client #	‡8 was still asleep. Staff					
	#9 indicated she	and staff #10 worked on					
	8/27/11 with clie	nts #1, #2, #3, #4, #5, #6,					
	#7, and #8. The o	clients had popcorn and a					
	movie. Staff #9 i	ndicated client #8 had					
	spoken with her	dad on the phone on					
	Saturday afterno	on (8/27/11), and					
	1	a good mood. Clients					
	went to bed in the	eir rooms and staff #9					
	stated client #8 b	ecame violent "for no					
		ng, nothing happened."					
		nto clients #5 and #1's					
		them. She broke mirrors					
	and pictures in th	ne bedroom hallway and					
		#2 and #6's bedroom and					
	hit client #2. Stat	ff #9 indicated client #8					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G393	B. WIN	G		09/08/20	011
NAME OF I	PROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		NORTH	I VERNON, IN47265		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		spit on staff #10. Client					
	`	om-mate) was holding					
		r shut to keep client #8					
		cated she and staff #10					
	~	of the bedroom and					
		scratched client #4. The					
		red client #8 had become					
	1 ^	nursday 8/25/11 and					
	_	f of the facility van when					
	it arrived at the fa	acility after work.					
		39 AM client #6 (when					
		nt #8's behaviors) stated,					
		nd threats terrifies me. I					
	don't like to be ca						
	threatened." Clie	ent #6 indicated client #8					
		er and make threats (to					
		rs/peers). Client #6 stated					
	client #8 had a bo	ehavior in the van "last					
	I	(11) and knocked her					
	l -	face while coming back					
	to the facility fro	m the workshop.					
	`	ualified Intellectual					
		essional assistant/QIDPa					
		9:30 AM indicated she					
		#8's psychiatrist on					
	_	sychiatrist had returned					
		vening of 8/30/11. The					
	psychiatrist recor						
		lient #8, but as of 11:00					
		the new medication for					
	client #8's behav	ior was not available for					
	her in the facility	7. The interview indicated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		COMPL	ETED
		15G393	B. WIN				09/08/2	011
NIAME OF T	DOMDED OF GLIDE IE.				DDRESS, CITY, STATE	, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	K.		113 JEN	ININGS ST			
	PMENTAL SERVIC				VERNON, IN4726	65		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN (EACH CORRECTIVE A	N OF CORRECTION		(X5)
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED T DEFICIE	TO THE APPROPRIAT	E	COMPLETION DATE
IAU		<u> </u>	-	IAG				DATE
	-	een called to the facility						
	_	of 8/27/11 regarding client						
		d was aware of her						
		uctive behaviors. The						
		ted Qualified Intellectual						
		Sessional staff #4 was						
		t #8's behaviors on						
		was on vacation at the						
		ey and had not made any						
	revisions to clien	nt #8's programming.						
		1						
		lient #6's guardian on						
		PM indicated she was						
		her daughter. The						
	interview indica	ted client #6 had a shunt						
	placed in her hea	ad (over her right ear area)						
	to drain fluids di	ue to her hydrocephalic						
	condition. The in	nterview indicated the						
	shunt had been p	placed at birth and again						
	when the client	was 15 years old. The						
		at age 15 had been an						
	•	tion when the apparatus						
		dislocated or clogged) and						
	,	nto cardiac arrest. The						
		ted the client was						
		uries about her head/face.						
	-	ated a past history of						
		orary book (by peer/client						
		sical aggression by client						
		"danger" to client #6's						
	•	uanger to enem #08						
	life.							
	1.1-3-2(a)							
	1.1 5 2 (u)							
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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/08/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
W0148	parents or guardia incidents, or changincluding, but not leactident, death, at absence. Based observation interview for 1 or and 2 additional of facility failed to leguardians were not incidents occurring. Findings include: Observations were facility on the even dead of the facility 4:40 If the facility 4:40 If the facility 4:40 If the facility dead of the faci		W0148	Since tihe opening oft tihis surve guardians have been contiactied tihe Supervised Group Living Div Manager or tihe QIDP Assistianti notifted oft tihe signiftcanti incidithati have occurred ati tihis groundome. The QIDP is no longer employed ati DSI and tihe SGL Division Manager is tihe acting Cati tihis time The QIDP Assistiant been retirained on requirementi notiftcation oft guardians and withis is tio be notied on tihe intie incidenti reporti ftormSGL Division Manager will tirain tihe new QID once hired, on tihese requireme Intiernal incidenti reportis are reviewed by tihe SGL division manager as well as all Stiatie reptio ensure proper notiftcation habeen made. Responsible for QA: QIDP Manager	by ision and entis ip UDP i has s ftor nere rnal on P ntis ortis s		

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Event ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G393		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE COMPI	LETED	
		15G393	B. WIN	IG		09/08/2	2011
	PROVIDER OR SUPPLIER		-	113 JEN	ADDRESS, CITY, STATE, ZIP CODE NNINGS ST	-	
DEVELO	PMENTAL SERVIC			NORTH	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION DATE
IAG		observed to be grouped		IAG			DAIL
	1	~ .					
	together in the facility's office/medication room with staff #6. Clients #1, #2, #3, #4,						
		mained in the facility's					
		#4 obtained the vacuum					
	cleaner and starte	ed to vacuum up the					
	broken glass outs	side the door to the office.					
	Client #8 vacuun	ned some of the glass					
		y staff #5 who also used					
		tpan. Staff #5 and client					
	#8 dried the kitchen floor and rearranged						
	the furniture.						
	Davious of facilit	v incident reports					
		y incident reports at Reports/AIR and					
	l `	Reports/MIR on 9/02/11					
		at 10:15 AM indicated					
	the following:	at 10.13 / HVI marcated					
	une reme wing.						
	1. An AIR by sta	aff #5 on 9/01/11 from					
	4:10 PM until 5:0	05 PM indicated client #8					
	was physically as	ggressive (slapped client					
	· ·	ent #4); damaged					
	1 1 2 4	items off walls, broke					
		ew over two chairs and					
		ocked glasses off of					
		n-compliant (argued with					
	1	ve (picked up glass shards					
		rm saying she would cut					
	1 ''	oally aggressive (called					
	_	"b" told peers she					
		yelled "I will kill ive me a knife I'll cut all					
	of you."	ive me a kime i ii cut an					
	or you.						<u> </u>

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CO LDING	00	COMPI	LETED
		15G393	B. WIN			09/08/2	011
	PROVIDER OR SUPPLIER		•	113 JEN	ADDRESS, CITY, STATE, ZIP CODE NNINGS ST I VERNON, IN47265	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	8:15 PM until 8:4 was physically a staff in the face a four clients hittir damaged propert breaking pictures furniture across t (argued with staff (cursing and yell) 3. A MIR dated staff #10 indicate physically aggres room-mate, clien hitting and scrate centimeter long that and 3 scratches the right side of her 4. A MIR dated staff #10 indicate physically aggres while she was in her room and slated areas on her cheek and a scrate. 5. A MIR dated staff #10 indicated areas on her cheek and a scrate.	ssive toward her t #4 who was asleep, thing her leaving a 3 mark to her right cheek wo inches long on the neck. 8/27/11 at 8:15 PM by ted client #8 was saive toward client #5 bed. Client #8 went into pped her. Client #5 had left upper arm and left tech on her left thumb. 8/27/11 at 8:15 PM by ted client #8 had smacked a reddened area on the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	15G393	A. BUI		00	09/08/2	
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2	
NAME OF I	PROVIDER OR SUPPLIER			1	NNINGS ST		
DEVELO	PMENTAL SERVIC			1	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		8/27/11 at 8:15 PM by		IAU			DATE
		· ·					
	staff #10 indicated client #8 was physically aggressive toward client #1 in						
		ped her and knocked her					
		her face. Client #1 had					
	red areas on her						
		<i>S</i>					
	7. A MIR dated	8/25/11 by staff #5 at					
		ed client #8 had slapped					
	herself on the rig	ht side of the face.					
	_						
	8. A MIR dated	8/25/11 by staff #5 at					
	3:10 PM indicate	ed client #4 reported					
	client #8 had hit	her on the left upper leg,					
	right upper arm a	and on her back.					
	O A MID datad	9/25/11 have sto ff #5 at					
		8/25/11 by staff #5 at ed client #7 had become					
		an when client #8 had					
	started yelling.	an when enem #6 nad					
	started yelling.						
	10. A MIR dated	d 8/25/11 by staff #5 at					
		ed client #3 reported					
		atched her on the right					
		marks. The first was 3					
	_	he second was 2 inches					
	in length.						
	Review of client	#3's record on 9/06/11 at					
		ed no evidence her					
	guardians had be	en notified of the					
	incidents/injuries	3.					
	Review of client	#6's record on 9/06/11 at					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

00 (X3) DATE SURVEY COMPLETED 09/08/2011		
ORESS, CITY, STATE, ZIP CODE INGS ST ERNON, IN47265		
PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
Additional staff have been act to each shift to ensure the he and safety of all residents in home. Staff have been train the plan of action and behave support plan for client #8. Q Assistant or SGL Division manager (acting QIDP), will observations in the home at weekly for one month to ensuplans are being implemented.	ealth this ed on ior IDP do least ure	
to a h th s A m o w p	to each shift to ensure the he and safety of all residents in some. Staff have been train- ne plan of action and behav- support plan for client #8. Q assistant or SGL Division manager (acting QIDP), will observations in the home at weekly for one month to ensure	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HVBK12 Facility ID:

ID: 000907

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/08/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ININGS ST VERNON, IN47265		
				<u> </u>			(V5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFRENCED TO THE APPROF DEFICIENCY)	SHOULD BE COMPLET	
IAG	Observations we facility on the ev 4:40 PM until 7:0 the facility 4:40 I broken pictures with floor in the firm which led to the room furniture will liquid was observation floor and the dimonof place. Staff #5 seated on a coucle client #8. Client couch crying. Client #8, and #7 were stogether in the far room with staff #5, #6, and #7 re office while RN cleaner and started broken glass outset Client #8 vacuum with assistance be a broom and dusted the furniture. At 5:12 PM, client #7 were observed and #7 were observed with the furniture. At 5:30 PM. Clients #1, #2, #5.	re conducted at the ening of 9/01/11 from 500 PM. Upon entrance to PM, broken glass and were observed to be on cont living room hallway family room. The family ras in disarray. A clear wed to be on the kitchen room tables were out to was observed to be in the family room with #8 was lying on the lients #1, #2, #3, #4, #5, observed to be grouped cility's office/medication #6. Clients #1, #2, #3, #4, mained in the facility's #4 obtained the vacuum red to vacuum up the room of the glass y staff #5 who also used the total staff #5 and client then floor and rearranged room of the staff #5 and client room floor and rearranged room of the staff #5, #6, reved to leave the office was observed to finish room meal of fish, reese, green beans, and		IAG	upheld. Random observa will continue after one mo Responsible for QA: QID Manager	nth.	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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000907

If continuation sheet Page 28 of 75

	OF CORRECTION	IDENTIFICATION NUMBER:			00		(X3) DATE COMPL	
		15G393	1	LDING			09/08/2	
		1.5555	B. WIN		DDDEGG OWN COA	TE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STA NNINGS ST	I E, ZIP CODE		
DEVELO	PMENTAL SERVIC	ES INC		1	VERNON, IN47	7 265		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S P	LAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIATI	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEF	ICIENCY)		DATE
	_	neal at 5:45 PM. Staff #5						
		sit with clients #1 and #5						
		par area. Clients #2, #3,						
		8 were observed to sit at						
	-	without staff sitting with						
		vas observed to be						
	•	ining room area but was						
		#8. Client #8 was						
		vith client #6 beside her						
	on the right and	client #3 around the						
	corner of the tab	le to client #8's left. RN						
	#2 left the facility at 6:00 PM on 9/01/11.							
	Observations we	ere conducted at the						
	facility on the ev	ening of 9/06/11 from						
	3:50 PM until 7:	50 PM. At 5:14 PM on						
	9/06/11, client #2	2 was observed to touch						
	client #8 on the l	left upper arm area as she						
	returned to the k	itchen area after setting a						
	bowl of green be	eans on the table. Client						
	#2 stated "leave	me alone, stop arguing						
	with me" and fro	owned at client #8 as she						
	touched her. Clie	ent #8 was observed to						
		back her right hand						
		vard client #2. Clients						
	-	5, #6, #7, and #8 were						
		e dinner at the facility at						
		5 was observed to sit						
		nd #5. Staff did not sit at						
		lents #1, #2, #3, #6, #7						
		oathing time at on 9/06/11						
	_	nt #8 exhibited frustration						
	-	r client #4 to be done						
	-	m. Staff #9 checked on						
		licated to client #8 she						
FORM CMS 2	567(02-99) Previous Version		LIVERAG	Eggility I	D: 000007	If continuation ab	aat D-	70 20 of 75
TUKWI UMS-2	JU/(UZ-99) Previous Version	ons Obsolete Event ID:	HVBK12	Facility I	^{ID:} 000907	If continuation sh	cci Pa	ge 29 of 75

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) MULTIPLE (A. BUILDING B. WING	00	li i	TE SURVEY IPLETED 1/2011	
	PROVIDER OR SUPPLIER		STREET 113 JE	raddress, city, state, zip c Ennings ST TH VERNON, IN47265	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Staff #5 and #9 v facility's office at the accessible ba at 6:40 PM. At 6 observed to open expressed her fru who was still in the Review of facility (Adverse Incident Medical Incident at 7:00 AM and at the following: 1. An AIR by sta 4:10 PM until 5:0 was physically as #2 in face, hit cli property (pulled two pictures, three exercise bike, kndining table); nor staff); self abusing and held to her at herself); and vertically staff and peers a hoped they died, everyone here, groof you." 2. An AIR by sta 8:15 PM until 8:4	oon and to be patient. vere observed to be in the rea and staff #6 was in throom bathing client #3 :40 PM, client #8 was the bathroom door and stration toward client #4, he bathroom. y incident reports at Reports/AIR and Reports/MIR on 9/02/11 at 10:15 AM indicated aff #5 on 9/01/11 from by PM indicated client #8 ggressive (slapped client ent #4); damaged items off walls, broke w over two chairs and ocked glasses off of a-compliant (argued with re (picked up glass shards rm saying she would cut bally aggressive (called "b" told peers she yelled "I will kill ive me a knife I'll cut all aff #9 on 8/27/11 from 40 PM indicated client #8 ggressive (she punched				

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Event ID:

HVBK12 Facility ID:

000907

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
		15G393	B. WIN			09/08/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NNINGS ST		
	PMENTAL SERVIC				I VERNON, IN47265		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	staff in the face a	and spit on staff, attacked					
	four clients hitting them in the head);						
		y (pulled items off walls					
		s and mirrors, threw he room); non-compliant					
	(argued with staf	**					
	` ~	ng and yelling at staff					
	and peers).						
	3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive to her room-mate,						
	1	ssive to her room-mate, as asleep, hitting and					
		aving a 3 centimeter long					
	_	cheek and 3 scratches					
	two inches long of	on the right side of her					
	neck.						
	4. A MIR dated	8/27/11 at 8:15 PM by					
	staff #10 indicate	ed client #8 was					
	1	ssive toward client #5					
		bed. Client #8 went into					
		pped her. Client #5 had					
		left upper arm and left sch on her left thumb.					
	check and a scrat	en on her left thumb.					
	5. A MIR dated	8/27/11 at 8:15 PM by					
		ed client #8 had smacked					
		a reddened area on the					
	left side of her fa	ce.					
	6. A MIR dated	8/27/11 at 8:15 PM by					
	staff #10 indicate	•					
	physically aggres	ssive toward client #1 in					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	15G393	- 1	LDING	00	09/08/2	
		100000	B. WIN		ADDRESS CITY STATE ZIR CODE	03/00/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	ES INC		1	VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		ped her and knocked her					
	' -	her face. Client #1 had					
	red areas on her right cheek. 7. A MIR dated 8/25/11 by staff #5 at						
		ed client #8 had slapped					
	herself on the rig	ht side of the face.					
		0/07/144					
		8/25/11 by staff #5 at					
	3:10 PM indicated client #4 reported client #8 had hit her on the left upper leg,						
	right upper arm and on her back.						
	9. A MIR dated	8/25/11 by staff #5 at					
		ed client #7 had become					
		an when client #8 had					
	started yelling.						
	10 A MID dated	8/25/11 by staff #5 at					
		ed client #3 reported					
		atched her on the right					
		o marks. The first was 3					
	-	the second was 2 inches					
	in length.	David Has E III					
	. <i>5</i>						
	Review of client	#3's record on 9/02/11 at					
	10:45 AM, indica	ated an entry by staff #9					
	on 8/27/11 from	7:00 AM to 10:00 PM					
	which indicated:	"became very upset					
	when (client #8)	had behavior (sic.) crying					
		o home. Stating (sic.) she					
	didn't want to be	here anymore." An entry					
	on 8/27/11 10:00	PM to 8:00 AM shift by					
	staff #8 indicated	l client #3 was crying at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393			LDING	NSTRUCTION 00	(X3) DATE COMPI 09/08/2	LETED	
	PROVIDER OR SUPPLIER		p. w.i.	STREET A	DDRESS, CITY, STATE, ZIP CODE ININGS ST VERNON, IN47265	1	
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION) sn't want to be here		TAG	DEFICIENCY)		DATE
	anymore, wants #8's) behavior or	to go home due to (client atburst." The entry by d client #3 was still upset					
	indicated entries daily basis by di	3 AM record review in client #8's record on a rect contact staff:					
	client #8 had been home and saying	3/11 by staff #3 indicated en "telling everyone to go g mean things to entry indicated client #8					
	cursed him and t Client #8 went in	e arm, called her dad, then hrew her cell phone. nto a peer's room and					
	had had "several	f #9 indicated client #8 temper tantrums					
	Cursing and bos On 8/25/11, staff	ay with several peers. sing." f #3 indicated client #8 on as she got in (sic.) van					
	at w/s (workshop On 8/27/11, staff	o) today." f #9 indicated client #8					
	(television)and b	ouch watching tv began yelling and cussing. ure and pictures (sic.)					
	struck by her and	or. 4 peers wore (sic.) d 1 staff was punched in ther spit on x2 (twice).'					
	1	ey policies and procedures 30 PM indicated a					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		15G393	B. WIN	G		09/08/2011	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
				1	NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		NORTH	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)	DATE	
	_	ng Procedure for					
	, , ,	Reporting Suspected					
	1	ect dated 4/12/2006. The					
		the agency prohibited					
		neglect. Definitions were					
	in the procedure:						
	"1 Dhygiaal Al	sa. The intentional or					
	I -	se: The intentional or					
		of physical injury					
	2. Verbal/Emotional Abuse: Includes oral,						
	written, and/or gestured language that						
		ging or derogatory					
		cludes demeaning tones					
	1	e. Includes unreasonable					
	•	timidation or humiliation.					
	1	ng an individual in a					
	situation that may	y endanger his or her life					
	or health; include	es failure to provide					
	appropriate care.	or supervision."					
		NT 110 0101111 1 1 2 7					
		N #2 on 9/01/11 at 4:35					
		ent #8 had a tantrum,					
		d threw furniture. The					
		ent #8 broke pictures					
		picked up some of the					
	-	ned to cut herself. RN #2					
	indicated client #	⁴ 8 had wanted to eat but					
	dinner was not re	eady. The interview stated					
	client #8 had beh	aviors "with no					
	warning." The in	terview indicated client					
	#8 had hit client	#2 in the left eye. The					
	interview indicat	ed client #8 had hit her					
	peers (clients #4	and #5) last weekend.					
	` `	N #2 on 9/01/11 at 4:55					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/08/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	P . W.L.	STREET A	DDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	ES INC		l	ININGS ST VERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAG	PM indicated the recommended a change but it had implemented be approvals had not client #2 stated that "(client #8) Client #5 stated she did "not wan Client #5 stated don't want it to hadraid it is going client #8 had "hi bed, she scratche mad because she last Saturday (8/ All clients, (#1, indicated they we when interviewed Client #3 indicated they we when interviewed Client #4 and (client #4 and (client #4) broke awoke and frigh room-mate, client Con 9/02/11 at 6:	e psychiatrist had psychotropic medication d not yet been cause the necessary of yet been obtained. on 9/01/11 at 4:50 PM hit me in the left eye." on 9/01/11 at 4:48 PM at to get beat up again." on 9/01/11 at 6:20 PM: "I happen again, that's all. I happen again. But, I'm to." Client #5 stated at my arm, I was laying in ed my left hand. She was excould not see her dad" (27/11). #2, #3, #4, #5, #6 and #7), were afraid of client #8 and on 9/01/11 at 4:53 PM. #4, #5, #6 and #7), were afraid of client #8 and on 9/01/11 at 6:25 do behaviors last Saturday time wherein client #8 hit itent #8's room-mate was mirrors and pictures and tened client #3's not #7.		IAG	DEPICIENCY)		DATE
	interviewed. Sta	ff #9 indicated clients #4					

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000907 If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/08/2011		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
				113 JENNINGS ST				
DEVELOPMENTAL SERVICES INC				NORTH VERNON, IN47265				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CC		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG			COMPLETION DATE	
1710	and #8 shared a bedroom the previous		+	1710			DATE	
	night and client #8 was still asleep. Staff							
	#9 indicated she and staff #10 worked on							
	8/27/11 with clients #1, #2, #3, #4, #5, #6,							
	#7, and #8. The clients had popcorn and a							
	movie. Staff #9 indicated client #8 had							
	spoken with her dad on the phone on							
	Saturday afternoon (8/27/11), and							
	appeared to be in a good mood. Clients							
	went to bed in their rooms and staff #9							
	stated client #8 became violent "for no							
	reason, no warning, nothing happened."							
	Client #8 went into clients #5 and #1's							
		them. She broke mirrors						
	and pictures in the bedroom hallway and							
	went into clients #2 and #6's bedroom and							
	hit client #2. Staff #9 indicated client #8							
	slapped her and spit on staff #10. Client							
	#4 (client #8's room-mate) was holding							
	the bedroom door shut to keep client #8							
	out. Staff #9 indicated she and staff #10							
	~	of the bedroom and						
		scratched client #4. The						
		ted client #8 had become						
	1 ^	hursday 8/25/11 and						
	_	f of the facility van when Cacility after work.						
	it arrived at the r	actify after work.						
	On 9/02/11 at 6:	39 AM client #6 (when						
		nt #8's behaviors) stated,						
		nd threats terrifies me. I						
	don't like to be c							
		ent #6 indicated client #8						
	would curse at her and make threats (to							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
THIE TENT	or condition	15G393	A. BUII B. WIN			09/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF P	PROVIDER OR SUPPLIEF	8		1	NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		NORTH	I VERNON, IN47265		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAU		rs/peers). Client #6 stated	+	IAU	,		DATE
		ehavior in the van "last					
		/11) and knocked her					
	- '	r face while coming back					
	_	om the workshop.					
	to the facility fre	in the workshop.					
	Phone interview	with staff #6 on 9/07/11					
	at 7:55 PM indic	ated client #8 had					
	another behavio	ral outburst on 9/06/11					
	after the surveyo	or left the facility. The					
	interview stated	the police had been called					
	owing to the "un	manageable" behaviors					
	exhibited by clie	ent #8. Phone interview					
	with staff #5 on	9/07/11 at 8:06 PM					
	indicated client #	#8 had become upset at					
	8:15 PM on 9/06	5/11 and had thrown a					
	lamp and an elec	etronic keyboard in the					
	•	n hallway. The client had					
		ype chair up the hallway					
	toward the living	g area. Staff #6 had taken					
		1, #5, and #6 into clients					
		oom for safety. Clients #3					
		ady in bed for night in					
		e others were taken there					
		e interview indicated					
		get into the clients'					
	bedroom but did	not.					
	Interview with C	Group Living Division					
		istrator #1 on 9/08/11 at					
	-	ated client #8 had severe					
		evening of 9/06/11 and					
		ed to intervene, the staff					
		the eye. 911 was called					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393			(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE COMP! - 09/08/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
W0153	of 9/01/11 and cl The interview in agency's policy to mistreatment, neg verbal, psychology 1.1-3-2(a) The facility must emistreatment, neglinjuries of unknow immediately to the officials in accordate established process Based on record 8 of 8 reportable (clients #1, #2, #2 facility failed to allegations of clieverbal and psychofficials (Bureau Disabilities Serviaccordance with established process Findings included Review of facility (Adverse Incident Medical Incident	o protect clients from glect and abuse (physical, gical). Insure that all allegations of lect or abuse, as well as a source, are reported administrator or to other ince with State law through dures. Insure that all allegations of lect or abuse, as well as a source, are reported administrator or to other ince with State law through dures. Insure that all allegations of lect or abuse, as well as a source, are reported administrator or to other incidents reviewed last, #4, #5 and #7), the immediately report lent to client physical, cological abuse to other and of Developmental leces/BDDS) in State law through edures.	W0153	The QIDP is no longer emposition. Stiaft did reporti approper intiernal policies. The Assistianti has been retirai agency policies and proced regarding reporting incide potiential abuse or neglect QIDP is hired tihis QIDP witirained on agency policies procedures as well as Medical regulations. The SGL Mandesignee reviews all intier reportis tio ensure complications are as All employee required tio updatie Abusy and Incidenti reporting tira annually. Additional retiration be required should non-combe discovered. Responsible ftor QA QIDP, Manager	ropriatiely QIDP ned on dures ntis oft ti Once a II be s and dicaid ager or nal incidenti ance in s are éNeglecti aining aining will ampliance	09/22/2011		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) MULTIPLE C A. BUILDING B. WING	00	l` ´	E SURVEY PLETED 2011		
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	8:15 PM until 8: was physically a staff in the face physically aggre (hitting them in property (pulled pictures and mir across the room with staff); and (cursing and yel 2. A MIR dated staff #10 indicat physically aggre client #4 who w scratching her le mark to her righ two inches long neck. 3. A MIR dated staff #10 indicat physically aggre she was in bed. Froom and slapped areas on her left and a scratch on 4. A MIR dated staff #10 indicat physically aggre she was in bed. Froom and slapped areas on her left and a scratch on 4. A MIR dated staff #10 indicat staff #10 indicat physically indicated staff #10 indicated st	as asleep, hitting and aving a 3 centimeter long to cheek and 3 scratches on the right side of her 8/27/11 at 8:15 PM by ed client #8 was assive to client #5 while Client #8 went into her and her. Client #5 had red upper arm and left cheek her left thumb. 8/27/11 at 8:15 PM by ed client #8 had smacked to a reddened area on the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		р. wп	STREET A	IDDRESS, CITY, STATE, ZIP CODE ININGS ST VERNON, IN47265	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	staff #10 indicated physically aggrees hallway slapped eyeglasses off of red areas on her red. 6. A MIR dated 3:10 PM indicated client #8 had hit her on the upper arm and on 7. A MIR dated 3:10 PM indicated agitated on the vestarted yelling. 8. A MIR dated 6:15 PM indicated client #8 had scrathigh leaving two inches long and the in length. Review of facility Developmental Inservices/BDDS in PM indicated the regarding clients had not been reported.	ssive to client #1 in the her and knocked her her face. Client #1 had right cheek. 8/25/11 by staff #5 at ed client #4 reported e left upper leg, right her back. 8/25/11 by staff #5 at ed client #7 had become an when client #8 had 8/25/11 by staff #5 at ed client #3 reported atched her on the right parks. The first was 3 he second was 2 inches by Bureau of Disabilities reports on 9/06/11 at 1:00 incidents of 8/27/11 #1, #2, #4, #5 and #8 ported to BDDS until DS reports indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A RULL DING 00			(X3) DATE SURVEY COMPLETED		
		15G393	A. BUILDING B. WING	G		09/08/20	
	ROVIDER OR SUPPLIER PMENTAL SERVICE		ST. 11	3 JENI	DDRESS, CITY, STATE, ZIP CODE NINGS ST VERNON, IN47265		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
		OP #2 had been notified					
	on 8/27/11 but ha						
	Administrator #1	until 8/31/11.					
		dministrator #1 on AM indicated the					
	incidents on 8/27						
	•	ureau of Developmental					
		ices/BDDS by Qualified					
	Intellectual Disab						
	Professional/QID	OP #2.					
	Interview with G	roup Living Division					
	_	istrator #1 on 9/08/11 at					
	11:00 AM indica	ted the incidents on					
	8/25/11 had not b	peen reported to BDDS.					
	1.1-3-1(b)(5)						
	1.1-3-2(a)						
W0154	_	ave evidence that all are thoroughly investigated.					
	Based on record	review and interview for	W015	4	SGL Division Manger or designee w		09/22/2011
	3 of 8 reportable	incidents reviewed			review all intiernal and BDDS incid		
	(clients #3, #4 an	nd #7), the facility failed			reportis tio identifty tihe need ftor investigations. Incidentis requiring		
	to ensure all alleg	gations were thoroughly			investigations will be tiracked tio	,	
	investigated.				ensure compliance witih agency		
	TO: 1:				policy and Medicaid regulations.		
	Findings include	•			SGL division manager will retirain currenti QIDP's and any QIDP hired	,	
					on policy regarding investigations.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2	2) MULTIPLE CO			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. 1	BUILDING	00		COMPL	
		15G393	В. V	WING			09/08/2	U11
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STA	ATE, ZIP CODE		
חבו יבו ס	DMENTAL OFFICE	NEC INC			NNINGS ST	7005		
	PMENTAL SERVIC			NORTH	VERNON, IN47	/ 2 05		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	,	TAG		r QA SGL Manager		DATE
		ty incident reports			Responsible ito	r QA SGL Manager		
	'	nt Reports/AIR and						
		t Reports/MIR on 9/02/11						
		at 10:15 AM indicated						
	the following:							
	1 A MID 1.4 1	0/25/11 1						
		8/25/11 by staff #5 at						
		ed client #4 reported						
		her on the left upper leg,						
	right upper arm a	and on her back.						
	2 4 1 4 1	0/07/11 1 4 66 117 4						
		8/25/11 by staff #5 at						
		ed client #7 had become						
	l -	ran when client #8 had						
	started yelling.							
	2 A MID 1 - 1	0/05/11 1						
		8/25/11 by staff #5 at						
		ed client #3 reported						
		atched her on the right						
		o marks. The first was 3						
		the second was 2 inches						
	in length.							
		_						
	Review of facilit	•						
	Developmental I							
		reports on 9/06/11 at 1:00						
		e incidents of 8/25/11						
		s #3, #4 and #7 had not						
	been investigated	d.						
		Group Living Division						
	. ~	istrator #1 on 9/08/11 at						
	11:00 AM indica	ated the no further						
	investigations/re	ports regarding the						
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G393	B. WIN			09/08/2	011
	ROVIDER OR SUPPLIER			113 JEN	DDRESS, CITY, STATE, ZIP CODE ININGS ST VERNON, IN47265		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	<u> </u>	TAG	DEFICIENCY)		DATE
W0159	Each client's active be integrated, coordinated mental results. Based on observation investigated and coordinates are supported by the coordinates of the coordinates	e treatment program must rdinated and monitored by a stardation professional. ation, record review and f 4 sampled clients (#1, and 4 additional clients (#8), the facility failed to fied mental retardation alified intellectual ssional/QIDP) integrated, coordinated each client's program. The QIDP to training in the clients' fing self protection. The atomitor client #6's ensure information and was present. The coordinate with others to so were reported and failed to ensure physical ents and wheelchair	W	0159	Each clienti's has been tirained on saftetiy response in emergency speciftcally regarding response tio possible aggressive behaviors ftror Clienti#8. Each clienti's programs be updatied tio include fturtiher tiraining on selft protiectionClienti #6's program plan/risk plan will be updatied tio include more inftormation regarding her shuntiff assessmentis ftor clienti#1 and #3 and wheelchair modiftcations ftor clienti#3 have been completied. The QIDP is no longer employed ati DS Stiaft did reporti appropriatiely per intiernal policies. The QIDP Assistic has been retirained on agency policies and procedures regarding reporting incidentis oft potiential abuse or neglecti. Once a QIDP is hired tihis QIDP will be tirained on agency policies and procedures as	n will	09/27/2011
	Findings include Please refer to W	: 153 for 8 of 8 reportable			well as Medicaid regulations. The SGL Manager or designee reviews intiernal incidenti reportis tio ensu compliance in tihese areas All employees are required tio updation.	re	
	incidents reviewe	ed (clients #1, #2, #3, #4,			Abuse/Neglecti and Incidenti		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	15G393	A. BUI	LDING	00	09/08/2	
		136393	B. WIN			09/00/2	011
NAME OF I	PROVIDER OR SUPPLIE	2		1	ADDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	CES INC			I VERNON, IN47265		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· · · · · · · · · · · · · · · · · · ·	he QIDP's failure to			reporting tiraining annually		
	1	ort allegations of client to			Additional retiraining will be requi	red	
	1	verbal and psychological			should non-compliance be discovered. SGL Division Manger of	nr	
	abuse to other of	fficials (The Bureau of			designee will review all intiernal a		
	Developmental l	Disabilities			BDDS incidenti reportis tio identift		
	Services/BDDS)	in accordance with State			need ftor investigations Incidentis		
	law through esta	blished procedures.			requiring investigations will be		
					tiracked tio ensure compliance wit	ih	
	Please refer to W	V154 for 3 of 8 reportable			agency policy and Medicaid		
	incidents review	red, (clients #3 and #4),			regulations. SGL division manager will retirain currenti QIDP's and an		
	for the QIDP's fa	ailure to ensure all			QIDP hired on policy regarding	У	
	,	thoroughly investigated.			investigations.		
		<i>5</i>			Responsible ftor QA QIDP/SGL		
	Please refer to W	V210 for 2 of 4 sampled			Manager		
	clients (#1 and #	(3), for the QIDP's failure					
	to ensure clients	' mobility needs were					
	assessed.						
	Please refer to W	V227 for 4 of 4 sampled					
	clients (#1, #2, #	² 3 and #4) and 4					
		s (#5, #6, #7 and #8), for					
		re to ensure the clients					
		how to protect themselves					
	against physical	•					
	Please refer to V	V240 for 1 additional					
	client, (#6), for t	he QIDP's failure to					
		nstructions regarding the					
	_	uma to the client's shunt					
	in the client's pro						
	·	- 1					
	Please refer to W	V436 for 1 of 4 clients					
	who used adapti	ve equipment, (client #3),					
	_	ailure to ensure her					
	<u> </u>						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G393	B. WIN			09/08/2	011
	PROVIDER OR SUPPLIER			113 JEN	ADDRESS, CITY, STATE, ZIP CODE NNINGS ST I VERNON, IN47265		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	1.1-3-3(a)	equipped properly.					
W0210	assessments or resupplement the proconducted prior to Based on observatinterview for 2 or and #3), the facility	am must perform accurate eassessments as needed to eliminary evaluation	W	0210	Clientis#1 and #3 each had a PT assessmenti on9/9/11 and any nev recommendations have been initiatied as parti oft tiheir progran Clienti#3 has received her new		09/15/2011
	9/01/11 from 4:4 client #3 was obstype wheelchair	ons at the facility on 0 PM until 7:00 PM served to use a collapsible for mobility. Client #1 walk about the facility			wheelchair and has had an OT assessmenti Again any new recommendations have been included in her program. Assessmentis will be updatied annually or more ftrequenti as needed due tio changing needs off tihe clienti QIDP will review all clie ftles tio ensure compliance Responsible for QA: QIDP/S Manager	nti	
	morning of 9/02/7:30 AM, client	ons at the facility on the 111 from 6:10 AM until 143 was observed to sible wheelchair instead					
	7:20 PM indicated included, but were palsy and bilatera	#1's record on 9/06/11 at ed her diagnoses re not limited to, cerebral al posterior tendon re record review indicated					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE :		
		15G393	A. BUII B. WIN			09/08/2	011
	PROVIDER OR SUPPLIER		'	113 JEN	ADDRESS, CITY, STATE, ZIP CODE NNINGS ST I VERNON, IN47265	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
iao	the client had a p evaluation with a exercise program review indicated	hysical therapy accompanying home a dated 6/2009. The the client's physical d not been reevaluated at		iao			BAIL
	7:16 PM indicate but were not limi spastic paraplegis the client had a p evaluation with a exercise program review indicated	a dated 9/2008. The the client's physical d not been reevaluated at					
	PM indicated clie	aff #3 on 9/06/11 at 4:30 ents #1 and #3 had not I Therapy evaluations at survey.					
	facility failed to i	was cited on 7/15/11. The implement a systemic n to prevent recurrence.					
	1.1-3-4(a)						
W0227	specific objectives client's needs, as i	sessment required by					

[·		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G393	B. WIN			09/08/2	011
NAME OF	PROVIDER OR SUPPLIER			STREET.	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	FROVIDER OR SUFFLIER			113 JE	NNINGS ST		
	PMENTAL SERVIC	ES INC		NORTH	H VERNON, IN47265		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	1 117	TAG	· · · · · · · · · · · · · · · · · · ·	ناء ما،	DATE
	1	ration, record review and	W	0227	Each clienti has been tirained on v tio do in tihe eventi oft aggressive	vnau	09/27/2011
		of 4 sampled clients (#1,			behaviors in tiheir home Each clie	nti'	
	1 '	nd 4 additional clients			s programs will be updatied tio		
		#8), the facility failed to			include fturtiher tiraining on selft		
		s were trained on how to			protiection QIDP's will be retirain	ed	
	l -	res against physical			on responsibilitiy tio revise clienti		
	aggression.				programs tio address speciftc need		
					as tihey arise QIDP's review client	is	
	Findings includ	e:			progress montihly tiowards goals Responsible ftor QA QIDP/SGL		
					Manager		
	Observations we	ere conducted at the			anage.		
	facility on the ev	vening of 9/06/11. At 5:14					
	PM on 9/06/11,	client #2 was observed to					
	touch client #8 c	on the left upper arm area					
	as she returned t	o the kitchen area after					
	setting a bowl of	f green beans on the table.					
	1	"leave me alone, stop					
	arguing with me	" and frowned at client #8					
	" "	er. Client #8 was					
	observed to frow	n and drew back her right					
	1	ist toward client #2.					
		3, #4, #5, #6, #7, and #8					
	1	have dinner at the					
		M. Staff #5 was observed					
	1 *	s #4 and #5. Staff did not					
		ith clients #1, #2, #3, #6,					
		ng bathing time at on					
		PM, client #8 exhibited					
		waiting for client #4 to					
	1	bathroom. Staff #9					
		nt #4 and indicated to					
		uld be done soon and to					
		£#5 and #9 were observed					
	1 -						
	to be in the facil	ity's office area and staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) MULTIPLE CO	00	(X3) DATE COMPI - 09/08/2	LETED	
	PROVIDER OR SUPPLIER		113 JEI	ADDRESS, CITY, STATE, ZIP CO NNINGS ST I VERNON, IN47265		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION
PREFIX TAG	#6 was in the acc client #3 at 6:40 #8 was observed door and express client #4, who was Review of facilit (Adverse Incident Medical Incident at 7:00 AM and at the following: 1. An AIR by sta 4:10 PM until 5:0 was physically as #2 in face, hit cli property (pulled two pictures, three exercise bike, kndining table); not staff); self abusive and held to her at herself); and vertisaff and peers a hoped they died, everyone here, goof you."	dessible bathroom bathing PM. At 6:40 PM, client to open the bathroom ed her frustration toward as still in the bathroom. The profession of the part	PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETION DATE
	8:15 PM until 8:4 was physically as staff in the face a four clients hittin	aff #9 on 8/27/11 from 40 PM indicated client #8 ggressive (she punched and spit on staff, attacked ag them in the head);				
	damaged propert	y (pulled items off walls				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		A. BUII	LDING	00	(X3) DATE COMPI 09/08/2	LETED
		B. WIN	STREET A	ININGS ST	00/00/2	
SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION
breaking pictures furniture across t (argued with staf aggressive (cursi and peers). 3. A MIR dated staff #10 indicate physically aggres room-mate, clien hitting and scrate centimeter long r and 3 scratches to right side of her 4. A MIR dated staff #10 indicated	s and mirrors, threw the room); non-compliant f); and verbally ng and yelling at staff 8/27/11 at 8:15 PM by ed client #8 was essive toward her t #4 who was asleep, ching her leaving a 3 mark to her right cheek two inches long on the neck. 8/27/11 at 8:15 PM by ed client #8 was		TAG			DATE
while she was in her room and slay red areas on her leader and a scrate of the staff #10 indicated client #2 and left left side of her factor of the staff #10 indicated staff #10 indicated staff #10 indicated physically aggress the hallway, slap eyeglasses off of	bed. Client #8 went into pped her. Client #5 had left upper arm and left ech on her left thumb. 8/27/11 at 8:15 PM by ed client #8 had smacked a reddened area on the ce. 8/27/11 at 8:15 PM by ed client #8 was ssive toward client #1 in ped her and knocked her ther face. Client #1 had					
	PROVIDER OR SUPPLIER DPMENTAL SERVIC SUMMARY'S (EACH DEFICIENT REGULATORY OR breaking pictures furniture across t (argued with staff aggressive (cursi and peers). 3. A MIR dated staff #10 indicate physically aggres room-mate, clien hitting and scratch centimeter long reand 3 scratches the right side of her 4. A MIR dated staff #10 indicate physically aggres while she was in her room and slar red areas on her of the cheek and a scrate staff #10 indicate physically aggres while she was in her room and slar red areas on her of the cheek and a scrate staff #10 indicate client #2 and left left side of her face. 6. A MIR dated staff #10 indicate client #2 and left left side of her face. 6. A MIR dated staff #10 indicate client #2 and left left side of her face.	OF CORRECTION IDENTIFICATION NUMBER: 15G393 PROVIDER OR SUPPLIER OPMENTAL SERVICES INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff	PROVIDER OR SUPPLIER DPMENTAL SERVICES INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff and peers). 3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the right side of her neck. 4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb. 5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face. 6. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #1 in the hallway, slapped her and knocked her eyeglasses off of her face. Client #1 had	PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER DPMENTAL SERVICES INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) breaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff and peers). 3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the right side of her neck. 4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb. 5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face. 6. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #1 in the hallway, slapped her and knocked her eyeglasses off of her face. Client #1 had	DENTIFICATION NUMBER: 15G393 STREET ADDRESS, CITY, STATE, ZIP CODE	OF CORRECTION IDENTIFICATION NUMBER: 15G393 BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Droaking pictures and mirrors, threw furniture across the room); non-compliant (argued with staff); and verbally aggressive (cursing and yelling at staff and peers). 3. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward her room-mate, client #4 who was asleep, hitting and scratching her leaving a 3 centimeter long mark to her right cheek and 3 scratches two inches long on the right side of her neck. 4. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #5 while she was in bed. Client #8 went into her room and slapped her. Client #5 had red areas on her left upper arm and left cheek and a scratch on her left thumb. 5. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 had smacked client #2 and left a reddened area on the left side of her face. 6. A MIR dated 8/27/11 at 8:15 PM by staff #10 indicated client #8 was physically aggressive toward client #1 in the hallway, slapped her and knocked her eyeglasses off of her face. Client #1 had

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/08/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	7. A MIR dated 3:10 PM indicate herself on the rig 8. A MIR dated 3:10 PM indicate client #8 had hit right upper arm a 9. A MIR dated 3:10 PM indicate agitated on the vi started yelling. 10. A MIR dated 6:15 PM indicate client #8 had scra thigh leaving two inches long and t in length. 1. Review of client	8/25/11 by staff #5 at ed client #8 had slapped ht side of the face. 8/25/11 by staff #5 at ed client #4 reported her on the left upper leg, and on her back. 8/25/11 by staff #5 at ed client #7 had become an when client #8 had 8/25/11 by staff #5 at ed client #7 had become an when client #8 had 8/25/11 by staff #5 at ed client #3 reported atched her on the right of marks. The first was 3 he second was 2 inches		'AG	DEFICIENCY)		DATE	
	Individual Suppo had been revised on what to do if s	ort Plan/ISP of 10/14/10 to include methodology someone physically						
	someone. The reinterdisciplinary the incidents of 8/25/11. When i 4:10 PM client #	She were frightened by cord review indicated no (IDT) meetings regarding 9/01/11, 8/27/11, or nterviewed on 9/06/11 at 1 stated client #8 had sses off" of her face and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393		A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 09/08/2	ETED	
	PROVIDER OR SUPPLIER		-	113 JEN	DDRESS, CITY, STATE, ZIP CODE ININGS ST VERNON, IN47265	-	
(X4) ID	PMENTAL SERVIC	TATEMENT OF DEFICIENCIES		ID I	VERNON, IN47205		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	COMPLETION DATE
TAG	she was still "sca #1 stated she did "b" anymore." no meetings rega episodes had bee 2. Review of cli- at 7:32 PM indic Individual Suppo had been revised on what to do if s attacked her or if someone. The re- interdisciplinary the incidents of 8/25/11. 3. Review of cli- at 7:16 PM indic Individual Suppo had been revised on what to do if s attacked her or if someone. The re- interdisciplinary the incidents of 8/25/11. When i 4:00 PM client # scared of client # happens." The in meetings regardi	red" of client #8. Client not want to be called The interview indicated arding the behavior in held with the client. ent #2's record on 9/06/11 ated no evidence her out Plan/ISP of 9/22/10 to include methodology someone physically she were frightened by ecord review indicated no (IDT) meetings regarding 9/01/11, 8/27/11, or ent #3's record on 9/06/11 ated no evidence her out Plan/ISP of 4/11/11 to include methodology someone physically she were frightened by cord review indicated no (IDT) meetings regarding 9/01/11, 8/27/11, or interviewed on 9/06/11 at 3 stated she was not 8 "unless something interview indicated no no go the behavior episodes		TAG	DEFICIENCY)	AIE	DATE
	had been held wi	th the client. ent #4's record on 9/06/11					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 09/08/2	ETED	
	PROVIDER OR SUPPLIEI			113 JEN	DDRESS, CITY, STATE, ZIP CODE ININGS ST VERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	at 7:26 PM indic of 11/12/10 had methodology on physically attack frightened by so indicated no intermeetings regards 9/01/11, 8/27/11 interviewed on 9/4 stated, when concerned or search client stated she and pointed at he same pointed at 6:44 PM indicated no intermeetings regards 9/01/11, 8/27/11 had be indicated no intermetings regards 9/01/11, 8/27/11 had be indicated no intermeetings regards 9/01/11, 8/27/11	been revised to include what to do if someone and her or if she were meone. The record review ordisciplinary (IDT) ing the incidents of a property of the incidents of include a property of the incidents of the incidents of the incidents of include and incidents of i					

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	(X2) MULTIPLE C A. BUILDING B. WING	00	COMPI 09/08/2	LETED
	PROVIDER OR SUPPLIER		STREET 113 JE	FADDRESS, CITY, STATE, ZIP COI ENNINGS ST TH VERNON, IN47265	D E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	(client #8). "The #6 had no trainin herself from aggrifightened of son interview indicat the behavior episthe client. 7. Review of client 7:40 PM indic of 10/07/10 had methodology on physically attack frightened by sor indicated no intermeetings regarding 9/01/11, 8/27/11, Confidential interwas following stauncharacteristic of indicated client #	rview indicated client #7 aff around which was of her. The interview 47 was manifesting fear result of client #8's				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15G393	A. BUI	LDING	00	09/08/2	
		130393	B. WIN			09/00/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NNINGS ST		
DEVELO	PMENTAL SERVICI	ES INC			VERNON, IN47265		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W0240		gram plan must describe ons to support the individual ence.					
	Based on observa	ation, record review and	l W	0240	Clienti#6's program/risk plan will l	oe e	09/27/2011
	interview for 1 ac	dditional client, (#6), the			revised tio include more speciftc		
	facility failed to i	include special			inftormation regarding her shunti		
	instructions regar	rding the possibility of			tihe potiential problems relatied t tirauma tio tihe shunt&tiaft will be		
	trauma to the clie	ent's shunt in the client's			retirained on tihe revised plan QIE		
	program plan.				will updatie plans annually or mor		
					ftrequenti as needed		
	Findings include:	:			Responsible ftor QA QIDP/SGL Manager , Agency nurse		
	Observations wer	re conducted at the					
	facility on the ev	ening of 9/01/11 from					
	4:40 PM until 7:0	00 PM. Upon entrance to					
	the facility 4:40 I	PM, broken glass and					
	broken pictures v	vere observed to be on					
	the floor in the fr	ont living room hallway					
	which led to the	family room. The family					
	room furniture w	as in disarray. A clear					
	liquid was observ	ved to be on the kitchen					
	floor and the dini	ing room tables were out					
	of place. Staff #5	was observed to be					
	seated on a couch	n in the family room with					
	client #8. Client #	#8 was lying on the					
	couch crying. Cl	lients #1, #2, #3, #4, #5,					
		observed to be grouped					
		cility's office/medication					
	room with staff #	6. Clients #1, #2, #3, #4,					
		mained in the facility's					
	office while RN	#4 obtained the vacuum					
	cleaner and starte	ed to vacuum up the					
		side the door to the office.					
		ned some of the glass					
					!		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HVBK12 Facility ID:

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STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL		
		15G393	B. WIN	G		09/08/20	011	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				1	NNINGS ST			
DEVELO	PMENTAL SERVIC	ES INC		NORTH	I VERNON, IN47265			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	OPRIATE		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		y staff #5 who also used						
		tpan. Staff #5 and client						
		nen floor and rearranged						
	the furniture.							
	Davies of the	#61a magainst 2 = 0/06/11 -4						
		#6's record on 9/06/11 at						
	6:45 PM indicate	· ·						
	included, but we	· ·						
		Grande Mal seizures,						
	1	imited peripheral and low rd review indicated an						
		ort Plan/ISP dated						
		companying Health Risk						
	1	N #2. A Health Risk Plan						
	1 * *	us by RN #2 indicated						
		placed at birth and again						
		and the HRP contained						
		egarding where the shunt						
	1 -	e risk of trauma to client						
	· ·	pose. The HRP for						
		tures indicated the client						
		essful situations. The						
		peripheral and low vision						
	indicated chent #	46 was vulnerable to falls.						
	Interview with R	N #2 on 9/01/11 at 4:35						
		ent #8 had a tantrum,						
		d threw furniture. The						
		ent #8 broke pictures						
		picked up some of the						
		ned to cut herself. RN #2						
		#8 had wanted to eat but						
		eady. The interview						
		*8 had behaviors "with no						
	mulcated chent #	ro nau uchaviois With ho						

000907

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 09/08/	LETED	
	PROVIDER OR SUPPLIER		113 JEN	ADDRESS, CITY, STATE, ZIP CO NNINGS ST I VERNON, IN47265	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	#8 had hit client interview indicate peers (clients #4 Interview with R PM indicated the recommended a change but it had implemented becapprovals had not On 9/02/11 at 6:: asked about clien "Name calling at don't like to be continued curse at had a bout client #8 had a bout client with the cl	cause the necessary of yet been obtained. 39 AM client #6 (when the #8's behaviors) stated, and threats terrifies me. I				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G393		(X2) MULTIPI A. BUILDING		RUCTION 00	(X3) DATE S COMPL 09/08/20	ETED	
NAME OF F	PROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP CODE	09/00/20	J11
DEVELO	PMENTAL SERVIC	ES INC			NGS ST ERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
W0266	client #6 went in interview indicat vulnerable to inju. The interview stabeing hit by a lib #7) and the physi. #8 was a "danger 1.1-3-4(a) The facility must e behavior and faciliare met. Based on observatinterview for 4 or #2, #3, and #4), at (#5, #6, #7, and #4 meet the Condition Behavior Manage Practices. The facility failed clients to be free psychological and failing to implement the client #8's behave the ensure law enforces behavior plan for the stable pl	raries about her head/face. ated a past history of rary book (by peer/client ical aggression by client it to client #6's life. Insure that specific client ty practices requirements ation, record review and if 4 sampled clients (#1, and 4 additional clients if 8), the facility failed to ion of Participation: ement and Facility d to ensure the rights of of neglect, verbal, d physical abuse by ient strategies to address iors. The facility failed to cement was used in a reclient #8 in lieu of gement techniques. The include behavior	W0266	i c c c c c c c c c c c c c c c c c c c	A Behavioral Clinician has been obtiained ftor Clien#8 and a Behavior Supporti Plan has been developed tio coincide with the Poft Action tihati was modiftedThe pehavior supporti plan includes information on tihe use oft behavior edication ftor client#8. The plan oft action was modifted tio indication eresponsibility oft detiermining when tio involve law enftorcement ftalls on tihe QID#on call person. Clienti#8's guardian has given verb approval ftor botih plans HRC approval was obtiained ftor botih plans and all stiaft have been cirained. A new psychiatiristi has becontiactied ftor Clien#8 as well as a counselor. Appointimentis are beinscheduled ftor each oft tihese Modiftcations are being made in tinome tio provide a privatie room fi	ior de g di al een ng	09/22/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HVBK12 Facility ID: 000907

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00		E SURVEY PLETED '2011	
	PROVIDER OR SUPPLIER		STRE 113	EET ADDRESS, CITY, STATE, ZI JENNINGS ST RTH VERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	Findings include Based on observer interview for 4 or #2, #3, and #4), and an ensure the rights neglect, verbal, prophysical abuse be strategies to addit The facility failed enforcement was for client #8 in him anagement technique client #8's plan. Based on observer interview for 4 or #2, #3, and #4), and #4, #4, #5, #6, #7, and an ensure their behaven courage the usen forcement in him anagement technique aggression and prophysical and self-	ation, record review and f 4 sampled clients (#1, and 4 additional clients (#8), the facility failed to of clients to be free of osychological and y failing to implement ress client #8's behaviors. d to ensure law a used in a behavior plan eu of behavioral eniques. The facility behavior medication in ation, record review and f 4 sampled clients (#1, and 4 additional clients (#8), the facility failed to avior practices did not e of local law ieu of behavior miques to manage client roperty destruction. The ensure behavior miques for verbal, abuse were included in	ı	CROSS-REFERENCED TO 1	tiurn provide a en#4 who was e All clienti's have door ich clienti has tio her door, in key tio each i and SGL ing QIDP or ti random i weekly tio or one montih s will continue er one montih	COMPLETION DATE
	client #8's program and implemented effectively; and the facility failed to include behavioral medication in the client's program.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUII		ONSTRUCTION 00	(X3) DATE S COMPL 09/08/2	ETED	
		15G393	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	09/06/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		1	I VERNON, IN47265		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Please refer to W clients (#1, #2, # additional clients facility failed to clients to be free and psychologica failing to implem programming eff. Please refer to W client (#8), the fause of local law as a substitute for programming. Please refer to W client (#8), the faincorporate interm#8's inappropriate physical, and self-plan. Please refer to W client who used a behavior, (client who used a behavior, (client who used a behavior, (client who used a client who used a behavior, (client who used a client who used a behavior, (client who used a client who used a	7127 for 4 of 4 sampled 3 and #4), plus 4 6 (#5, #6, #7 and #8), the ensure the rights of the from physical, verbal al abuse by a peer by nent behavioral fectively. 7288 for 1 additional acility failed to ensure the enforcement was not used or active treatment 7289 for 1 additional acility failed to ventions to manage client the behaviors (verbal, of abuse) into her program 7312 for 1 additional drugs for inappropriate #8), the facility failed to 7the behavior drug was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		15G393	B. WIN			09/08/20)11
			D. ((1))		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1	NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		1	I VERNON, IN47265		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0288	•	nage inappropriate client					
	for an active treatr	ver be used as a substitute					
	1	ation, record review and	w	0288	A Behavior Supporti Plan has bee	n	09/22/2011
		dditional client (#8), the	''	0200	developed which includes	"	07/22/2011
					replacementi behaviors tio work v	vitih	
	-	ensure the use of local			clienti#8 on. The plan oft action w		
		was not used as a			modifted tio indicatie tihe		
	substitute for act	ive treatment			responsibilitiy oft detiermining wh	nen	
	programming.				tio involve law enftorcementi ftall:	I	
					tihe QIDP/on call person. Clienti#8	I	
	Findings include	:			guardian has given verbal approva	I .	
					ftor botih plans HRC approval was	I	
	1. Observations	were conducted at the			obtiained ftor botih plans and all s have been tirained QIDP assistian	I .	
	facility on the ev	ening of 9/01/11 from			and SGL division manager/acting	iu	
		00 PM. Upon entrance to			QIDP or designee will conducti		
		PM, broken glass and			random observations ati leasti we	ekly	
	=	were observed to be on			tio ensure compliance ftor one		
	-	ont living room hallway			montih Random observations wil	ı	
		family room. The family			continue ati leasti montihly after o	one	
		ras in disarray. A clear			montih		
		•			Responsible ftor QA QIDP/SGL		
	•	ved to be on the kitchen			Manager		
		ing room tables were out					
	-	was observed to be					
		h in the family room with					
		#8 was lying on the					
	couch crying. C	lients #1, #2, #3, #4, #5,					
	#6, and #7 were	observed to be grouped					
	together in the fa	cility's office/medication					
	room with staff #	#6. Clients #1, #2, #3, #4,					
		mained in the facility's					
		#4 obtained the vacuum					
	cleaner and started to vacuum up the broken glass outside the door to the office.						
	_						
	Client #8 vacuumed some of the glass						

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	15G393	A. BUI	LDING	00	COMPL 09/08/2	
		130393	B. WIN			09/06/2	011
NAME OF	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	ES INC		1	I VERNON, IN47265		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
	with assistance b	by staff #5 who also used					
	a broom and dustpan. Staff #5 and client						
	#8 dried the kitc	hen floor and rearranged					
	the furniture. In	terview with RN #2 on					
	9/01/11 at 4:35 F	PM indicated client #8					
	had a tantrum, b	roke mirrors and threw					
	furniture. The R	N indicated client #8					
	broke pictures co	overed in glass, picked up					
	some of the glas	s and threatened to cut					
	herself. RN #2 indicated client #8 had						
	wanted to eat but dinner was not ready.						
	The interview stated client #8 had						
	behaviors "with no warning." The						
	interview indicat	ted client #8 had hit client					
	#2 in the left eye	e. The interview indicated					
	client #8 had hit	her peers (clients #4 and					
	#5) last weekend	I.					
		were conducted at the					
	1	vening of 9/06/11. At 5:14					
	1	client #2 was observed to					
	1	on the left upper arm area					
		o the kitchen area after					
	"	green beans on the table.					
	1	"leave me alone, stop					
	" "	" and frowned at client #8					
		er. Client #8 was					
	1	n and drew back her right					
		ist toward client #2.					
	1	3, #4, #5, #6, #7, and #8					
	were observed to	have dinner at the					
	facility at 5:15 P	M. Staff #5 was observed					
	to sit with clients	s #4 and #5. Staff did not					
	sit at the table w	ith clients #1, #2, #3, #6,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/08/2	ETED	
NAME OF	PROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				1	ININGS ST		
	PMENTAL SERVIC				VERNON, IN47265		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	#7 and #8. Durir	ng bathing time at on					
	9/06/11 at 6:30 PM, client #8 exhibited						
	frustration while waiting for client #4 to						
	be done with the	bathroom. Staff #9					
	checked on clier	at #4 and indicated to					
	client #8 she wo	uld be done soon and to					
	1 *	#5 and #9 were observed					
		ity's office area and staff					
		cessible bathroom bathing					
	client #3 at 6:40 PM. At 6:40 PM, client						
	#8 was observed to open the bathroom						
	door and expressed her frustration toward						
	client #4, who w	as still in the bathroom.					
	Phone interview	with staff #6 on 9/07/11					
	at 7:55 PM indic	ated client #8 had					
	another behavio	ral outburst on 9/06/11					
	after the surveyo	or left the facility. The					
	interview stated	the police had been called					
	owing to the "un	manageable" behaviors					
	1	ent #8. Phone interview					
		9/07/11 at 8:06 PM					
	1	#8 had become upset at					
		5/11 and had thrown a					
	1 -	etronic keyboard in the					
	1 -	m hallway. The client had					
		ype chair up the hallway					
	1	g area. Staff #6 had taken					
	1	4, #5, and #6 into clients					
		oom for safety. Clients #3					
	1	ady in bed for night in					
		"The interview indicated					
	1	get into the clients'					
	I chichi πο u icu to	get into the chefts					

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NAME OF	PROVIDER OR SUPPLIER	II		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	NNINGS ST I VERNON, IN47265		
	PMENTAL SERVIC			L	I VERNON, IN47200		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	bedroom but did						
	Interview with C	Group Living Division					
	Manager/Administrator #1 on 9/08/11 at						
	11:00 AM indica	ated client #8 had severe					
	behaviors on the	evening of 9/06/11 and					
	when staff #9 tri	ed to intervene, the staff					
	was punched in	the eye. 911 was called					
	according to the	facility's Plan of Action					
	of 9/01/11 and client #8 calmed herself.						
	The Plan of Acti	on for dealing with client					
	#8's behaviors was reviewed on						
	9/01/2011 at 8:4	5 PM which included the					
	following:						
	"If (aliant #9!a) h	achaviar bacamag					
	` ′	behavior becomes Chysically threatening to					
		nues for more than 15					
		Qualified Intellectual					
		essional/on call pager will					
		911 will be called. This					
		uous aggressive behavior					
		does not apply to					
	situations in whi	* * *					
		but calms herself.					
		estructive behavior is only					
		her own property, staff					
		attempt to prevent this.					
		LY intervene if her					
		ng harm to herself. If this					
		vior continues without					
		to herself or others for 45					
		ill notify QIDP/on call					
	I minutes, stan Wi	in nonly Qide/on can					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393			(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/08/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE NNINGS ST I VERNON, IN47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	enforcement to in behaviors rather effective behavior strategies such as Nonviolent Crisis	or the use of local law attervene with client #8's than incorporating			
W0289	manage inapproprincorporated into the program plan, in a (4) and (5) of this seased on observation interview for 1 and facility failed to it to manage client	ation, record review, and dditional client (#8), the ncorporate interventions #8's inappropriate l, physical, and self rogram plan.	W0289	A behavior supporti plan has been developed and approved by tihe tieam as parti oft clier#8's program plan. Clienti#8's guardian has give approval ftor tihis plan and HRC approval has been obtiained All stiaft have been tirained on tihis p QIDP assistianti and SGL division manager/acting QIDP or designee will conducti random observations leasti weekly tio ensure compliance	n en Ian

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CO	INSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	15G393	A. BUII		00	09/08/2	
		130393	B. WIN			09/00/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	FS INC		I	I VERNON, IN47265		
		TATEMENT OF DEFICIENCIES		ID			(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	Observations we	re conducted at the			ftor one montih Random		
		ening of 9/01/11 from			observations will continue ati leas	sti	
	1	00 PM. Upon entrance to			montihly after one montih		
		PM, broken glass and			Responsible ftor QA QIDP/SGL		
	· ·	vere observed to be on			Manager		
	1 ^	ont living room hallway					
		family room. The family					
		as in disarray. A clear					
		ved to be on the kitchen					
	_	ing room tables were out					
	of place. Staff #5 was observed to be						
	seated on a couch in the family room with						
	client #8. Client	#8 was lying on the					
	couch crying. Cl	lients #1, #2, #3, #4, #5,					
		observed to be grouped					
	together in the fa	cility's office/medication					
	room with staff #	⁴ 6. Clients #1, #2, #3, #4,					
	#5, #6, and #7 re	mained in the facility's					
	office while RN	#4 obtained the vacuum					
	cleaner and starte	ed to vacuum up the					
	broken glass outs	side the door to the office.					
	Client #8 vacuun	ned some of the glass					
	with assistance b	y staff #5 who also used					
	a broom and dust	tpan. Staff #5 and client					
	#8 dried the kitch	nen floor and rearranged					
	the furniture.						
	Review of facility	y incident reports					
	(Adverse Inciden	nt Reports/AIR and					
	Medical Incident	Reports/MIR on 9/02/11					
	at 7:00 AM and a	at 10:15 AM indicated					
	the following:						
	1. An AIR by sta	aff #5 on 9/01/11 from					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G393		(X2) MULTIPLE C A. BUILDING B. WING	00	li i	e survey Pleted /2011	
	PROVIDER OR SUPPLIER		STREET 113 JE	FADDRESS, CITY, STATE, ZIP C ENNINGS ST TH VERNON, IN47265	CODE	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC INCLUDENTIEVING INFORMATIONS	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION
TAG	4:10 PM until 5:0 was physically as #2 in face, hit cli property (pulled two pictures, thre exercise bike, kn dining table); not staff); self abusiv and held to her a herself); and vert staff and peers a hoped they died, everyone here, g of you." 2. An AIR by st 8:15 PM until 8:4 was physically as staff in the face a four clients hittir damaged propert breaking pictures furniture across t (argued with staff aggressive (cursi and peers). 3. A MIR dated staff #10 indicate physically aggres room-mate, clien hitting and scrate centimeter long re	ng and yelling at staff 8/27/11 at 8:15 PM by ed client #8 was	TAG	DEPRIENCY)		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G393		(X2) MULTIPLE CC A. BUILDING B. WING	00	ì í	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CO NNINGS ST I VERNON, IN47265	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
IAG	right side of her	·	IAG			DAIL
	staff #10 indicated physically aggress while she was in her room and slared areas on her cheek and a scrate staff #10 indicated client #2 and left left side of her factor	bed. Client #8 went into pped her. Client #5 had left upper arm and left tch on her left thumb. 8/27/11 at 8:15 PM by ed client #8 had smacked a reddened area on the ice. 8/27/11 at 8:15 PM by ed client #8 was ssive toward client #1 in ped her and knocked her ther face. Client #1 had right cheek. 8/25/11 by staff #5 at ed client #8 had slapped tht side of the face. 8/25/11 by staff #5 at ed client #4 reported ther on the left upper leg,				

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	PROVIDER OR SUPPLIER		113	JEN	DDRESS, CITY, STATE, ZIP CODE ININGS ST VERNON, IN47265	09/00/2	011
				1111	VERTICON, 11147 203		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	.	CY MUST BE PERCEDED BY FULL	PREFI TAC		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	IAC	' 	BEITCHE TY		DATE
	started yelling.						
	6:15 PM indicated client #8 had scrathigh leaving two inches long and to in length. Review of client 9:28 AM indicated assessment dated information regal assessment indicher frustration the outbursts, rather about her frustration the outbursts, rather about her frustrategies to calmalysis indicated for client #8 but history of emotion disturbances." Ac Analysis, the clied depression, mood behaviors and set The Case Analysis been treated for the she was "4 or 5 y"several inpatien	8/25/11 by staff #5 at ed client #3 reported atched her on the right o marks. The first was 3 the second was 2 inches #8's record on 9/02/11 at ed a Case Analysis 12/28/11 which included riding her history. The ated client #8 "expresses rough behavioral than being able to talk tions and implementing in herself." The Case ed no formal diagnoses indicated she "has a long onal and behavioral eccording to the Case ent has exhibited "major d swings, explosive lif injurious behaviors." is indicated client #8 had behavioral issues since years old" and she has had thospitalizations" the rred in "approximately					
	2004."						
	The record review	w indicated client #8 had					
	a behavior suppo	ort program/BSP dated					
	6/4/11. The BSP	indicated client #8 had					

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	PROVIDER OR SUPPLIER		D. WIN	STREET A	NDDRESS, CITY, STATE, ZIP CODE NNINGS ST I VERNON, IN47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E NATE	(X5) COMPLETION DATE
	aggressive behave been revised when violent behaviors. The BSP only conclient if she becan verbally aggressiverbally redirect area to calm or discoloring and try to feelings. There we self injurious behaviored threatening/demodestruction or phosphological plants. The 9/02/11 9:28 indicated entries daily basis by direct An entry on 8/18 client #8 had been home and saying everyone." The elbit herself on the cursed him and the Client #8 went in knocked over her	ntained strategies for the me became upset or ve. The staff were to and guide her to a quiet to activities such as to get her to discuss her vere no methodologies for naviors, eaning language, property ysical aggression g, or spitting) in the AM record review in client #8's record on a rect contact staff: //11 by staff #3 indicated n "telling everyone to go mean things to entry indicated client #8 arm, called her dad, then herew her cell phone. It is a quiet to a peer's room and					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G393	B. WIN			09/08/2	011
NAME OF E	PROVIDER OR SUPPLIER		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					NNINGS ST		
DEVELO	PMENTAL SERVIC	ES INC		NORTH	I VERNON, IN47265		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	On 8/25/11, staff #3 indicated client #8						
		on as she got in (sic.) van					
	at w/s (workshop) today."						
	0 0/27/11 4 60	2110: 1: 4 1 1: 4 110					
	On 8/27/11, staff #9 indicated client #8 "was laying on couch watching tv						
	, , ,	· ·					
	· ′	egan yelling and cussing.					
		are and pictures (sic.)					
		r. 4 peers wore (sic.)					
	1	1 1 staff was punched in					
	the face and anot	her spit on x2 (twice)."					
	Interview with R	N #2 on 9/01/11 at 4:35					
		ent #8 had a tantrum,					
		d threw furniture. The					
		ent #8 broke pictures					
		picked up some of the					
		ned to cut herself. RN #2					
	~	48 had wanted to eat but					
	client #8 had beh	eady. The interview stated					
	·	terview indicated client #2 in the left eye. The					
		ed client #8 had hit her					
	peers (chents #4	and #5) last weekend.					
	Interview with O	ualified Intellectual					
	·	essional assistant/QIDPa					
		9:30 AM indicated she					
		o the facility on the					
		11 regarding client #8's					
	and was aware of						
		active behaviors. The					
		ed Qualified Intellectual					
	interview marcat	ca vaaiiiica iiitoliootaai					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THEFTERN	or conduction	15G393	A. BUILDING B. WING		09/08/2011
NAME OF P	PROVIDER OR SUPPLIER		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
DEVELO	PMENTAL SERVICI	ES INC		IENNINGS ST TH VERNON, IN47265	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Disabilities Professional staff #4 was notified of client #8's behaviors on		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	vacation at the tir	/11 but she was on me of the survey and had isions to client #8's nming.			
W0312	behavior must be a of the client's indiv directed specificall and eventual elimi which the drugs ar Based on record 1 additional clien inappropriate behavior and the drug was included. Findings included Review of client 9:28 AM indicated program/ISP date which indicated s	review and interview for at who used drugs for navior, (#8), the facility the use of the behavior d in the client's plan.	W0312	A behavior supporti plan has beed developed and approved by tihe tieam as parti oft clien#8's program plan. The behavior supporti plan includes inftormation on tihe use behavior medication ftor client#8 Clienti#8's guardian has given approval ftor tihis plan and HRC approval has been obtiained All stiaft have been tirained on tihis plan and ger/acting QIDP or designed will conducti random observation leasti weekly tio ensure complian ftor one montih Random observations will continue ati least	m oft . olan es as ati

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	PROVIDER OR SUPPLIER		113 JEN	ADDRESS, CITY, STATE, ZIP CODE NNINGS ST I VERNON, IN47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	(antipsychotic) 2 benztropine 0.5 r side effects of the review indicated prescribed the at- medication Saph which had been in The ISP had not the use of the Sar criteria for the m in the ISP. Interview with Q Disabilities Profe #3 on 9/06/11 at ISP had not yet be Qualified Intelled Professional/QII available to revisivacation at the ti	daily, risperadone mg. daily and mg. twice daily for the e medications. The record the psychiatrist had ypical antipsychotic ris 5 mg. at hour of sleep implemented on 9/02/11. been revised to include phris nor had withdrawal edication been included pualified Intellectual essional assistant/QIDPa 4:30 PM indicated the been revised since		montihly after one montih Responsible ftor QA QIDP/SGL Manager	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2011		
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
W0436	repair, and teach of informed choices a eyeglasses, hearing communications and devices identified as needed by the Based on observation of 4 clients who (client #3), the fawheelchair was experienced by the Based on observation of 4 clients who is the fawheelchair was experienced by the Based on observation of 4 client #3, the fawheelchair was experienced by the Based on observation of 9/01/11 from 4:4 client #3 was obstype wheelchair in the buring observation of 9/02/7:30 AM, client statistical through the collapsion of the experienced by the Based on observation of 9/02/7:30 AM, client statistical by the Based on observation of 9/06/11 from 3:4	ids, braces, and other by the interdisciplinary team client. ation and interview for 1 used adaptive equipment, acility failed to ensure her equipped properly. : ons at the facility on 0 PM until 7:00 PM served to use a collapsible for mobility. ons at the facility on the 11 from 6:10 AM until #3 was observed to sible wheelchair instead ons at the facility on 5 PM until 7:50 PM served to use a collapsible	W0436	Clienti#3's has received a new wheelchair. QIDP's will monition each clienti's equipmenti tio ensitihati all ift ftunctioning properly modiftcations and repairs will be made timely. Responsible for QA: QIDP/Manager	and		

000907

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/08/2011		
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	AM indicated clinew wheelchair with the correct valso not fitted with handles. Staff #4 could not reach thandles with the was in need of remobilize herself Client #3 indicather new wheelch hallway of the fausing it yet. This deficiency value facility failed to plan of correction 1.1-3-7(a)	ed on 9/06/11 at 4:30 PM hair was in the back heility but she was not was cited on 7/15/11. The implement a systemic in to prevent recurrence.					
W0484	chairs, eating uter meet the developr Based on observe of 4 sampled clie and 4 additional		W0484	QIDP assistianti has made sure tih dining utiensils are available in tih home. Stiaft have been retirained tihe importiance oft each clienti b able tio use dining areas and servito meeti tiheir developmential ne QIDP assistianti and SGL division manager/acting QIDP or designee will conducti random observation	e on eing deeds		
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: HVBK12 Facility ID: 000907 If continuation sheet Page 74 of 75							

HVBK12 Facility ID:

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 09/08/2011		
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
TAG	During observati PM, clients #1, # #8 were observed of fish sticks, ma beans and fruit. include knives, s Clients #1, #2, #3 were observed to facility at 5:15 P consisted of tater fried smoked sau did not include k Interview with st 9/06/11 indicated available for use knives were used capacity. This deficiency w facility failed to	ons on 9/01/11 at 5:45 22, #3 #4, #5, #6, #7 and do to eat the evening meal acaroni and cheese, green The table service did not poons or napkins. 3, #4, #5, #6, #7, and #8 of have dinner at the M on 9/06/11. The meal actors, green beans, and asage. The table service nives for meat cutting. aff #6 at 5:25 PM on table knives should be by clients, only sharp I in a limited, supervised was cited on 7/15/11. The implement a systemic in to prevent recurrence.	TAG	leasti weekly tio ensure compliftor one montih Random observations will continue atilimontihly after one montih Responsible ftor QA QIDP/SGL Manager	ance		

000907